PROPOSAL FORM – ROUND 10
SINGLE COUNTRY APPLICANT

SECTIONS 1-2

Deadline for submission: 20 August 2010, 12 Noon CET

Applicant Name	Country Coordinating Mechanism		
Country	Thailand		
Income Level → *Refer to Annex 1 in the Round 10 Guidelines*	Lower-middle income		
Applicant Type	☒ CCM	☐ Sub-CCM	☐ Non-CCM
If your country is also part of a Round 10 multi-country proposal, indicate for which disease(s)	☐ HIV	☐ Tuberculosis	☐ Malaria
Currency	☐ USD	☐ Euro	

Disease		Title	Does the proposal include cross-cutting health systems strengthening interventions? → *Indicate yes or no and Include sections 4B and 5B in one proposal only*	Is this being submitted as a consolidated disease proposal? → *Indicate yes or no*
HIV → *Choose* *either* *Regular or MARPs reserve*	☐ Regular ☐ MARPs Reserve	"Comprehensive HIV/AIDS Care, Support and Social Protection for Affected and Vulnerable Children Living in High Prevalence Area to Achieve Full Potential in Health and Development: CHILDLIFE"	No	No
Tuberculosis		Universal Access to TB Care in Vulnerable Populations (UATBV)	No	No
Malaria		Moving Towards The Elimination of *Plasmodium falciparum* Through Intensified Malaria Control in Thailand	No	No

IMPORTANT NOTE:

We strongly recommend applicants use the information below as an essential reference while completing the Proposal Form and other application documents. It is very important to carefully read each section in the Round 10 Guidelines at the same time as filling out the proposal and other application documents in order to submit a complete application. All other Round 10 documentation is available on the Global Fund's website.

MANDATORY SECTIONS OF THE PROPOSAL FORM:

A) Complete sections 1-2 only once per applicant[1]

Section 1 — Funding Summary and Contact Details

Section 2 — Applicant Summary and Eligibility

- Membership Details (CCM or Sub-CCM)
- Eligibility Form (if applicable)

B) Complete sections 3-5 once for each disease proposal[2]

Section 3 — Proposal Summary

Section 4 — Program Description

- Performance Framework <u>or</u> Consolidated Performance Framework
- Pharmaceutical and Health Products List (if applicable)
- Work Plan

Section 5 — Funding Request

- Detailed Budget

OPTIONAL SECTIONS OF THE PROPOSAL FORM:

If relevant, complete sections 4B and 5B only once per applicant and include with only one disease proposal

Section 4B — Cross-cutting health systems strengthening interventions

Section 5B — Cross-cutting health systems strengthening funding

[1] The applicant only needs to submit a single section 1-2 as part of the application, even when applying for multiple diseases.
[2] The applicant needs to submit a section 3-5 for each disease proposal submitted.

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SECTION 1: FUNDING SUMMARY AND CONTACT DETAILS

1.1 Funding summary						
Disease	Round 10 Funding Request (USD)					
	Year 1	Year 2	Year 3	Year 4	Year 5	Total
HIV	7,137,026	8,261,221	9,961,885	10,515,019	6,213,416	42,088,567
Tuberculosis	6,239,326	6,105,447	6,303,430	6,450,500	6,618,126	31,716,829
Malaria	23,312,506	18,731,141	18,208,900	20,527,466	20,201,818	100,981,831
Cross-cutting HSS interventions → *Insert disease name*	-	-	-	-	-	-
Total Round 10 Funding Request						174,787,227

1.2 Contact details		
	Primary contact	Secondary contact
Name	Dr. Supakit Sirilak	Dr. Petchsri Sirinirund
Title	Director of Bureau of Policy and Strategy, Office of Permanent	Senior Expert in Preventive Medicine/ Department of Disease Control
Organization	Ministry of Public Health	Ministry of Public Health
Mailing address	Office of the Permanent Secretary of Ministry of Public Health, Nonthaburi, Thailand 11000	Department of Disease Control Ministry of Public Health, Nonthaburi, Thailand 11000
Telephone	(66) 2590 1500	(66) 2590 3221
Fax	(66) 2591 5040	(66) 2965 9569
E-mail addresses	konc62@yahoo.com, ccmthailand@gmail.com	spetchsri@gmail.com, ccmthailand@gmail.com

1.3 List of Abbreviations and Acronyms used by the Applicant

Acronyms	**Meaning**
TC	CCM-Technical Committee
PLHIV	People Living with HIV
TNCA	Thai NGOs Coalition on AIDS
TUC	Thai Ministry of Public Health - US CDC Collaboration
MSDHS	Ministry of Social Development and Human Security
DDC	Department of Disease Control
DOH	Department of Health
TNP+	Thai Network of People Living with HIV
GMS	Grant Management Solutions

List of Abbreviations and Acronyms used by HIV/AIDS R10

Acronym/ Abbreviation	Definition
ACCESS	AIDS ACCESS Foundation (Thailand)
ACHIEVED	Aligning Care and Prevention of HIV/AIDS with Government Decentralization to Achieve Coverage and Impact
AEM	Asian Epidemic Model
AIDS	Acquired Immune Deficiency Syndrome
AIDSNet	AIDSNet Foundation (Thailand)
ANC	Antenatal clinic
ART	Antiretroviral Therapy
ARV	Antiretroviral
AusAID	Australian Government Overseas AID Program
BATS	Bureau of AIDS, TB and STI
CABA	Children Affected by HIV/AIDS
CAG	Child Action Group
CBO	Community Based Organization, Civil Society Organizations and groups
CCC	Comprehensive Care Center operated by Thai Network of PLHIV (TNP+)
CCM	Country Coordinating Mechanism

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CPA	Country Coordinating Mechanism
CPC	Child Protection Committee (Provincial)
CSO	Civil Society Organization
DDC	Department of Disease Control
DSDW	Department of Social Development and Welfare
ECAT	Enhancing Care and Treatment project (GFATM funded)
EID	Early Infant Diagnosis
FDC	Family Development Center
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GO	Government
HIV	Human Immunodeficiency Virus
HSS	Health Systems Strengthening
IBBS	Integrated Biological and Behavioral Survey
ICCO	Interchurch organization for Development Cooperation
IDU	Injecting Drug User
LOA	Local Administrative Organization
LSDF	Life Skills Development Foundation
M&E	Monitoring and Evaluation
MARP	Most-at-risk Populations
MCH	Maternal and Child Health
MICS	Multiple Indicators Cluster Survey
MOI	Ministry of Interior
MOPH	Ministry of Public Health
MSDHS	Ministry of Social Development and Human Security
MSF	Medicins San Frontier
MSM	Men who have Sex with Men
NAMc	National AIDS Management Center
NAP	National AIDS Program
NASA	National AIDS Spending
NGO	Non-governmental Organization

NHSO	National Health Security Office
OVC	Orphan and Vulnerable Children
PATH	Program for Appropriate Technology in Health
PCM	Provincial Coordinating Mechanism
PLHIV	People Living with HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission (of HIV)
PPAT	Planned Parenthood Association of Thailand
PR	Principal Recipient (Global Fund)
R1-RCC	Round 1, Rolling Continuation Channel
RTF	Raks Thai Foundation (Thailand)
SDA	Service Delivery Area
SPSS	Social Protection Systems Strengthening
STI	Sexually Transmitted Infection
SW	Sex Workers
TAO	Tambon (sub-district) Administration Organization
TNAF	Thai National AIDS Foundation
TNP+	Thai Network of People Living with HIV/AIDS
TPBS	Thai Public Broadcasting Service
TRP	Technical Review Panel (Global Fund)
TUC	Thai-US Collaboration on HIV/AIDS
UA	Universal Access
UC	Universal Coverage Scheme
UNFPA	United Nations Populations Fund
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNICEF	United Nations Children's Fund
VCT	Voluntary Counseling and Testing
WVFT	World Vision Foundation (Thailand)
YPLHIV	Young People Living with HIV/AIDS

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SECTION 2: APPLICANT SUMMARY AND ELIGIBILITY

CCM applicants	Sub-CCM applicants	Non-CCM applicants
➔ *Complete sections 2.1 & 2.2* ➔ *Delete sections 2.3 & 2.4*	➔ *Complete sections 2.1, 2.2 & 2.3* ➔ *Delete section 2.4*	➔ *Complete section 2.4* ➔ *Delete section 2.1, 2.2 & 2.3*

2.1 Members and operations

2.1.1 Membership summary → *tick the relevant box*

Sector Representation	Number of members
☑ Academic/educational sector	2
☑ Government	9
☑ Non-government organizations (NGOs)/community-based organizations	5
☑ People living with the diseases	1
☐ People representing key populations[3]	-
☑ Private sector	3
☑ Faith-based organizations	1
☑ Multilateral and bilateral development partners in country	3
☑ Other → *specify:* 2 Independent Senior Health Experts and 1 politician	3
Total Number of Members: → *Must equal the number of members in the Membership Details form*[4]	27

[3] See the definition of key populations found in the Round 10 Guidelines.

2.1.2 Broad and inclusive membership Since your last eligible application to the Global Fund:		
(a) Have there been any changes in members since the last time the CCM (or Sub-CCM) was determined eligible?	☐ No → *go to section 2.1.2 (c)*	**X YES** → *go to section 2.1.2 (b)*
(b) If 'Yes' in part (a), ~~please~~ describe in the space below how those new members were selected.		
There have been changes in 2 CCM members since Round 9 proposal submission, including people living with HIV and people representing the target population. They were selected from their constituencies as follows: People living with HIV The Chairperson of the Thai National Committee of PLHIV in Thailand who serves as a CCM member is elected every two years. As the term of Mr. Boriphat Donmoon came to an end, the new chairperson, Mr. Aphiwat Kwangkaew has been elected at the national assembly of PLHIV in May 2010 and has been also represent PLHIV in the CCM. The letter dated 17th June 2010 informed the CCM of the change and Mr. Kwangkaew has replaced Mr. Donmon since 17 June 2010. (Annex 17) Representing youth Similarly, the national network of youths, 'Youth Net', Youth for Change network (formerly the Youth AIDS Network of Thailand) has also elected new leader and a letter dated 25th February 2010, requested a change of its representative on the CCM from Mr. Kittpan Kanjina to Ms. Jittiya Wajee. (Annex 18)		
(c) Is there continuing active membership of people living with and/or affected by the diseases?	☐ No	**X YES**
(d) Is there continuing active membership of both males and females and/or any improvement toward gender balance among members?	☐ No	**X YES**

2.1.3 Member knowledge and experience in cross-cutting issues
(a) Health Systems Strengthening: Describe the capacity and experience of the CCM (or Sub-CCM) on health systems strengthening issues
The CCM is a multidisciplinary team comprising of 27 representatives who are managers of the national programs to control the three diseases (HIV/AIDS, tuberculosis and malaria) and people with expertise in public health, community health and community health system strengthening and multilateral and bilateral development partners. Out of 27 CCM members, 9 are from the governmental sector in particular; in particular, there are 3 senior managers from the MOPH directly responsible for managing daily operations associated with the three diseases. The other 6 members represent key ministries relating to the current grants. This representation creates a synergy among the programs and the necessary links between the CCM and national coordinating mechanisms. Furthermore, such organization of the CCM provides the opportunity to consider and discuss systemic health problems associated with implementation of the three disease programs financed by the Global Fund. Three representatives from multilateral and bilateral organizations (UNAIDS, WHO and MOPH - US CDC), 2 representatives from university and education sector, and 2 independent senior health experts are all capable in health system strengthening through their own direct experience as well as through their constituencies' respective missions. The CCM members from civil society organizations, include representatives from Thai NGOs Coalition on AIDS, faith-based organizations, and PLHIV with experience in community-based approaches. These members provide critical information on how to strengthen the health system to better respond to the needs of the community. In addition and when required, the CCM Thailand uses the services of other experts, both nationals and expatriates, who are not members of the CCM. Thus, in drawing up the proposals and to gain a better understanding of the impact of the three diseases on the health system and people's life, the CCM has used not only staff from the Ministry of Public Health, but has also tapped into a broad range of technical support provided by various development partners, local organizations and institutions.
(b) Gender: Describe the capacity and experience of the CCM (or Sub-CCM) in gender and also issues concerning sexual orientation and gender identities. • Expertise and skills in methodologies to assess gender differentials in disease burdens and their consequences (including differences between men and women, boys and girls), and in access to and the utilization of prevention, treatment, care and support programs; and Comprehensive knowledge of the factors that make women and girls and sexual minorities vulnerable such as harmful gender norms, behavior, attitudes and practices that underlie the differentials in the spread of HIV (e.g. gender based violence, discrimination and stigma, sexual female mutilation, early marriage, masculinity, etc).
The CCM has always paid a lot of attention to issues and problems of gender, sexual minorities, and children during proposal planning, reviewing, approving, coordinating, monitoring and supervision. Serving on the CCM Thailand are people who, on account of their roles, operate at the very core of gender-related issues from policy development to program implementation including; 1) National Economic and Social Development Board, 2) Thai Red Cross, 3) WHO, 4) UNAIDS, 5) Thai MOPH – US CDC Collaboration (TUC), 6) Thai Network of People Living with HIV/AIDS (TNP+), 7) Thai NGO Coalitions on AIDS (TNCA), 8) Institution for Population and Social Research, 9) Thai Youth Network,

10) the Ministry of Social Development and Human Security (MSDHS) and 11) the Ministry of Public Health. The expertise of CCM members and non-members has been used to integrate gender-related issues in the development of this proposal and this expertise will also be used in the future implementation, monitoring and evaluation of program if approved.	
(c) How many members of the CCM (or Sub-CCM) have considerable expertise in one or both of the areas described in section 2.1.3 (b)?	11
(d) Multi-sectoral planning: Describe the capacity and experience of the CCM (or Sub-CCM) in multi-sectoral program design.	

The CCM always considers multi-sectoral participation from the planning phase onwards as a key for project success. The composition of the CCM Thailand is thus inclusive of representatives from the non-governmental sector (66.7%): civil society, private sector, faith-based organizations, people infected with/affected by diseases, multilateral and bilateral development partners, senior health experts and the university/education sector, and representatives from the governmental sector (33.3%): Ministry of Public Health, Ministry of Foreign Affairs, Ministry of Labour, Ministry of Education, Ministry of Social Development and Human Security, Bangkok Metropolitan Administration and the National Economic and Social Development Board. This multifaceted partnership ensures a multidimensional vision and is conducive to effective multi-sector planning.

In addition, when drawing up the proposals, we consulted beyond the members of the CCM to gather contributions from representatives of various sectors at national and local level that are engaged in the fight against the three diseases. This approach has enabled us to accomplish multi-sector planning which will, in turn, enable multi-sector and decentralized implementation.

The CCM has created three disease-specific Technical Committees (TCs) comprising of both CCM members and non-CCM members. The groups meet regularly, share their expertise, assist in drafting the program proposals, provide suggestions on work plans and during implementation they assist in oversight the program of PR and SRs progress.

The CCM Secretariat arranges to convene CCM Plenary, prepares and distributes documents related to the CCM Plenary, and is in charge of communication between CCM, CCM members, PRs and the Global Fund to ensure the timely communication and effective solutions to each problems incurred.

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2.2 Eligibility

2.2.1 Application history	
☑ Recently applied for funding in Round 8, or Round 9, or RCC Waves 5-8 and was determined eligible	→ *Complete sections 2.2.2 to 2.2.8*
☐ Last applied for funding before Round 8 or RCC Wave 5	→ *Complete Eligibility Form* → *Complete sections 2.2.5 to 2.2.8* → *Do not complete sections 2.2.2 to 2.2.4*
☐ Determined ineligible at last application	→ *Complete Eligibility Form* → *Complete sections 2.2.5 to 2.2.8* → *Do not complete sections 2.2.2 to 2.2.4*

CLARIFIED SECTION 2.2.2 (d)

2.2.2 Proposal development process

(a) Describe the process used to invite submissions for possible integration into the proposal from a broad range of stakeholders including civil society and the private sector, at the national, sub-national and community levels, as well as from key populations, where applicable.

→ *Explain the process for each disease proposal in the application*

The CCM Thailand has appointed 3 Technical Committees (TCs), each of which includes governmental and nongovernmental organizations as well as multilateral development partners (Annex 1), to manage the proposal development process. The process specific for each disease proposal is as follows:

HIV proposal

It was resolved at the CCM meeting on 2 March 2010 to revise the Round 9 proposal for resubmission. The Technical Committee - HIV (TC-HIV) has since this point in time has managed the development of the proposal based on a transparent and documented process with a fixed timeline. A broad range of stakeholders were invited to review the Round 9 proposal with TRP comments, and redefine target populations and strategies for Round 10 (Annex 2). Revised strategies were also approved in the CCM meeting.

The invitation for proposals and subsequently for PRs and SRs was done in 2 steps. Together with the other 2 disease proposals, the first announcement, calling for organizations interested in participating in the proposal, was done through the daily newspaper during 13 March - 11 April 2010, www.thailandccm.org and group emails (Annex 3). The second announcement, calling for expression of interest to be PRs, SRs, SSRs and Implementing Agencies (IA), with more details of the proposal strategies, project sites and process of PR selection, was through the CCM website 14-31 May 2010 (Annex 4).

TB proposal

As Thailand has requested the support from the Global Fund on Tuberculosis since 2002 to present (Round 1, Round 6 and Round 8). The Technical Committee on Tuberculosis (TC-TB) under the CCM Thailand proposed to call for concept papers for Round 10 to realize the country gap as the minute of meeting 1/ 2010 (Annex 20).

The formal call for TB for Round 10 was released by the CCM secretariat during 13 March - 24 May 2010, through various public channels including of daily newspapers, website: www.thailandccm.org and group emails and inviting interested organizations in becoming Implementing Partners (IPs) for the TB Round 10 Proposal (Annex 3). The call aimed to request concept papers from broad range of stake

holders to become partners in Round 10. After the deadline of submitting date (May 24, 2010) there were 18 concept papers from various organizations interested in participating TB proposal development in Round 10 (Annex). Malaria proposal

The TC-Malaria reviewed the Round 9 Malaria Proposal and the Malaria situation in Thailand and discussed TRP comments regarding weaknesses in the Round 9 proposal and recommendations for strengthening and agreed to put together a strengthened Round 10 Malaria proposal addressing the same issue of emerging Plasmodium Falciparum resistant to Artemisinin – based Combination therapy which has significantly increased around the Thai-Cambodia border and the need for an urgent response with GFATM support. The TC-Malaria agreed with the TRP recommendation to expand to coverage to the Thai-Myanmar border and other provinces with high incidence of malaria and with large numbers of migrants allowing for broader transmission (Annex 19). (They provided Annex 12.)

The TC-Malaria proposed this issue to the CCM Plenary meeting held on 2 March 10. The CCM approved developing the Malaria Round 10 proposal under the framework proposed by the TC-Malaria.

The CCM Secretariat Office launched a call for implementing partners for the malaria component together with HIV/AIDS and TB during 13 March – 11 April 2010 through various public channels like the other 2 disease proposals.

(b) Describe the process used to transparently review the submissions received for possible integration into the proposal.

→ *Explain the process for each disease proposal in the application*

The following steps were adhered to in review of submissions for possible integration into the proposal.The CCM met periodically to ensure a transparent process for inclusion of inputs from interested parties.

HIV proposal

The Round 9 proposal with TRP comments and current gaps were reviewed during a 3-day workshop with a broad range of stakeholders, including government organizations, NGOs, PLHIV and multilateral development partners (Annex 5). In addition, the TC-HIV organized the meetings considering specific issues with experienced organizations from both national and provincial levels. (Annex 6)

Based on the results from the review by a broad range of stakeholders, the TC-HIV redefined target populations, strategies and project sites (Annex7). 49 organizations applied to participate in the proposal as PRs, SRs, SSRs and IAs after the second announcement, calling for expression of interest (Annex 8). After selection of 2 PRs and 12 SRs, all of them fully participated in series of planning workshops.

TB proposal

TC-TB was organizing the meeting 2-3/2010 held on 2 June 2010 in order to review the submitted concept papers and find out the applicants who met the criteria that suppose to comprehensively continue working to improve TB control among vulnerable populations in Thailand. TC-TB consideration of all applicants based on existing gaps -new activities and new target groups. Then the applicants were informed of the results within the month of June 2010 (TC-TB minute 2/2010). Agencies that have been selected and approved the concept was invited through email and calling to review epidemiologic data among high risk groups, involved with gap analysis with a small group discussion and get involved in the team of proposal development, between June to August 2010 by the core team designated by MOPH and consultants from WHO HQ & SEARO.

Malaria proposal

The submissions from 17 organizations were received; they were given opportunities to present their interest on involving in Malaria Round 10 proposal development to the TC-Malaria on 19 April 2010 . All applicants were assessed based on pre-established criteria (priorities, gaps, activities, and stakeholders' record of accomplishment). Twelve applicants met the minimal requirements and accepted to participate in the proposal development process. CCM was appointing Malaria Proposal Developing Team on responsible for developing malaria Round 10 proposal. The said team consisted of representatives from BVBD, MC, SMRU, BIOPHICS, IOM, RTF, Kenan, DDC, C-Malaria and CCM Secretariat Office (Annex 21).

(c) Describe the process used to ensure the input of people and stakeholders other than CCM (or Sub-CCM) members in the proposal development process. → *Explain the process for each disease proposal in the application*

ONE PAGE MAXIMUM

HIV proposal

The TC-HIV and selected PRs, SRs with technical support from UNICEF, UNAIDS, TUC and WHO organized series of workshops to develop proposal. The site visit was organized to Chiang Rai province, where has been hit by the HIV/AIDS problem since the first phase of epidemic in Thailand, in order to have more inputs from the relating stakeholders from both GOs and NGOs as well as community in the field (Annex 9). Apart from the Thai Network of PLHIV (TNP+) as one SR, the meeting was organized to get comments of the draft of the proposal from HIV infected youths, PLHIVs and women living with HIV groups (Annex 10). In addition, the MOCK review was done by 3 experts giving inputs for improving the proposal.

TB proposal

Bureau of Tuberculosis as a focal point for National TB Control Program in Thailand is responsible with the core team of proposal development has closely participated with Technical Expert on TB program and contributed the experiences from all key partners particularly from NGOs, civil society and high risk groups of TB control, In addition, CCM representatives from TB Team was nominated and actively attended "The Technical Review Meeting (Mock Reviews by SEARO) for Round 10 Proposals", during 26 – 30 July 2010 at WHO/SEARO, New Delhi, India. Finally, the input and feedbacks from the Mock Reviews, CCM members from UNAIDS, WHO country and USG have been recommended this proposal qualified to submit to GFATM Round 10.

Malaria proposal

The proposal development was under responsibility of the TC-Malaria. The members of the committee in majority composed by members who are not CCM members but are experts in the relevant diseases. The TWGs are also made of technical experts from both the government and nongovernmental sectors thus improving the quantity and quality of background information to be used for proposal development. Technical Assistance was also sought for the development of the proposal with financial support of WHO for Malaria and encourage to attended a "Technical Review Meeting (Mock TRP)" for Round 10 as well. The draft proposals organized by WHO SEARO in New Delhi provide comments and inputs were taken into consideration in finalizing the proposals.

(d) Attach a signed and dated version of the minutes of the meeting(s) at which the CCM (or Sub-CCM) members decided what to include in each disease proposal.	*Annexes 3 and 12*

2.2.3 Process to oversee program implementation

(a) Describe the process used to ensure the input of stakeholders other than CCM (or Sub-CCM) members in the ongoing oversight of program implementation.

Currently, the CCM has appointed 3 Technical Committees (TC) of each disease program, composed of CCM and non-CCM members, from all sector groups (NGOs, PHA organizations, Government, social societies, multi and bi-lateral developmental organizations and private sectors). The TCs are in charge of the supervision and evaluation of the programs during implementation. The TCs receive updates from the PRs on a regular basis, hold frequent meetings and present to the CCM their findings on a quarterly basis. Independent site assessment done by the TCs is conducted if necessary. The TCs also present viable recommendations for overcoming challenges and removing bottlenecks in the way of implementation. Recommendations are given to the CCM and the PR for necessary actions.

The CCM has been working with the Grant Management Solution (GMS) with the purpose to improve oversight function of the CCM. The draft of Thailand CCM oversight plan has been developed (Annex

11). Oversight committee members will be selected based on their expertise in 1) implementation of public and private sector interventions in HIV, TB and malaria programs at the national and/or provincial levels; 2) financial and/or accounting in medium / large public or private sector organizations; and 3) advocacy and oversight from the perspective of people living with or affected by the diseases.

(b) Describe the process used by the CCM (or Sub-CCM) to oversee program implementation.

Currently, the 3 Technical Committees are working for CCM to oversee the program implementation. The PRs have to report the progress in the quarterly meetings of TC. TC summarize main points, particularly the issues on challenges and the needs to coordinate with national policy and program in the quarterly meeting of CCM, meanwhile all PRs also present their progress and challenges together with the documented reports. The LFA is also invited to the CCM meetings.

As the result of working with GMS, the draft of Thailand CCM oversight plan states definition and rationale and also principles of oversight. The CCM oversight committee will be established to facilitating the decision-making process of the CCM members by reporting on the 3 main areas, including financial, programmatic and performance issues. The oversight will relate to all phases and areas of grant implementation.

The oversight work plan will be developed to reflect the required frequency and scheduling of oversight activities: annually, quarterly, according to PR reporting cycles, annual calendar of site visits and attendance at regular PR-SR meetings, and ad hoc basis. (Annex 11)

CLARIFIED SECTION 2.2.4

2.2.4 Process to select Principal Recipient(s)

(a) Describe the process used to make a transparent and documented selection of each of the Principal Recipient(s) nominated in this proposal.

→ *Explain the process for each Principal Recipient for each disease*

HIV proposal

The first call announcement was done together with the other 2 diseases proposal. The second announcement gave details of target population, strategies as well as project sites and called for expressions of interest to be PRs, SRs, SSRs and IAs. The applicants had to submit information according to requirement of CCM to show their competencies (Annex 4). The third announcement called those applying to be PRs to present their visions and competencies to manage the program (Annex 4). The TC-HIV interviewed 4 applicants and reviewed their documents and using scores with the discussion among the committee to rank all applicants. The results were presented in the CCM meeting for consideration and made final decision (Annex 12).

There were 4 NGOs applied to be PR and under the above process, one was selected to be PR. In the CCM meeting, in consideration on the integration to the national program and sustainability of the GF supported program, the CCM decided to have another PR from the government and assigned TC-HIV to ask for the interest of relating government organizations directly responsible for the care and support to children affected by HIV, including the Ministry of Social Development and Human Security (MSDHS), Department of Health (DOH) and Department of Disease Control (DDC) respectively (Annex 12). The MSDHS and DOH are interested to join the program as SRs. Thus DDC was selected to be another governmental PR.

TB proposal

Between proposal developments processes, the interested organizations had to do the self assessment to clarify themselves about their capacity to be PR, SR or SSR in TB Round 10 proposal. The TC-TB then reviewed all the applications, and presented this recommendation to the CCM. The CCM has approved the selection of DDC as the Nominating PRs for the TB Round 10 proposal on the plenary CCM meeting hold on 4 June 2010 .

Malaria proposal
The TC-Malaria launched the call for Expression of interest to be PR for the Malaria Round 10 during May 1 – 10, 2010. The proposal framework, the application form as well as list of requested supportive documents were posted on the websites. There was only Department of Disease Control (DDC) that applied for the said call.

The CCM Secretariat Office distributed the application forms and supportive documents to all TC members for review before the member's meeting. The TC-Malaria held the meeting on May 20, 2010 to interview the experiences and capacity discuss and select the DDC to be PR for this program. DDC has capacities as it is responsible for national Malaria program and has high experience with GFATM grants management. The selection was proposed to the 4 June 2010 CCM meeting and the CCM nominated DDC a single PR as the TC-Malaria recommended.

(b) Attach the signed and dated minutes of the meeting(s) at which the CCM (or Sub-CCM) members nominated the Principal Recipient(s) for each disease.	*Annex 12*

2.2.5 Non-implementation of dual track financing

Dual track financing means that at least one government sector and one non-government sector Principal Recipient have been nominated for each disease in this proposal. If relevant, provide an explanation below as to why dual track financing has not been applied for any of the disease proposals in this application.

HALF PAGE MAXIMUM

TB proposal and Malaria proposal

1. The Department of Disease Control is the only one organization that submitted the expression of interested in applying the application to be a PR and Non government organization does not apply for this position as they have assessed their ability to be in the SR and SSR levels.

2. The Department of Disease Control has a capability and experiences on grant management of the Global Fund since Round 1, Round 6 and Round 8 for TB program and Round 2 and Round 7 for Malaria program.

2.2.6 Managing conflicts of interest

(a) Are the Chair and/or Vice-Chair of the CCM (or Sub-CCM) from the same entity as any of the nominated Principal Recipient(s) for any of the disease proposals in this application?	**X YES** → *go to (b) and then section 2.2.8* ☐ No → *go to section 2.2.8*
(b) If yes, attach the plan for the management of actual and potential conflicts of interest.	13

2.2.7 Proposal endorsement by members The Membership Details form has been completed with the signatures of all members of the CCM (or Sub-CCM)	☑ → *Tick this box to confirm that the Membership Details form, with signatures, is attached to the application*

CLARIFIED SECTION Section 2: Eligibility		List annex name and number
CCM and Sub-CCM applicants only		
2.2.2(a)	Process used to invite submissions for possible integration into each disease proposal	- TC members (1) - Minutes of CCM meeting, 2 Mar 10 (2) - Announcement through daily newspaper (3) - Call for expressions of interest (4)
2.2.2(b)	Process used to review submissions for possible integration into each disease proposal	- Summary of a stakeholder meeting, 3-4 May (5) - Summary of meetings on HSS issues (29) - Minutes of TC-HIV meeting, 7 May 10 (7) - List of applicants to be PR, SR, SSR and IA for HIV proposal (8)
2.2.2(c)	Process used to ensure the input of a broad range of stakeholders in the proposal development process	- Summary of site visit in Chiang Rai (9) - Summary of meeting with key populations (10)
2.2.3(a)	Process to oversee grant implementation by the CCM (or Sub-CCM)	- Draft of Thailand CCM Oversight Plan (11)
2.2.3(b)	Processes used to ensure the input of a broad range of stakeholders in grant oversight process	- Draft of Thailand CCM Oversight Plan (11)
2.2.4(a)	Process used to select and nominate the Principal Recipient(s) for each disease proposal	- Call for expressions of interest (4) - Minutes of CCM meeting, date (12)
2.2.6	Conflict of Interest policy	- Current conflict of interest policy (13) - Draft of new conflict of interest policy (14)
2.2.7	Minutes of the meeting at which the proposal was finalized and endorsed by the CCM (or Sub-CCM)	- Minutes of CCM meeting, 10 Aug 10 (15)

2.2.7	Endorsement of the proposal by all CCM (or Sub-CCM) members	Membership Details Form (16)
Other documents relevant to sections 1 and 2 attached by applicant: *→ Add extra rows to this section of the table as required to ensure that documents directly relevant are attached*		
2.1.2 (b)	How new members be selected	- Minutes of TNP+ meeting on (17) - Minutes of youth net meeting on (18)
	TC-HIV/AIDS minutes	No.1/2010-4/2010
	TC-TB minutes	No.1/2010-3/2010
	TC-Malaria minutes	No.1/2010-3/2010

PROPOSAL FORM – ROUND 10
SINGLE COUNTRY APPLICANT

SECTIONS 3-5: HIV

3. PROPOSAL SUMMARY

<table>
<tr><td rowspan="3">3.1 Transition to a single stream of funding

(a) Select only one of the three options:</td><td colspan="2">☐ Option 1: Transition to a single stream of funding by submitting a consolidated disease proposal
→ go to section 3.1 (b)
Relevant sections are marked in RED throughout the proposal form</td></tr>
<tr><td colspan="2">☐ Option 2: Transition to a single stream of funding during grant negotiation
→ go to section 3.1 (b)
Relevant sections are marked in RED throughout the proposal form</td></tr>
<tr><td colspan="2">☒ Option 3: No transition to a single stream of funding in Round 10
Relevant sections are marked in RED throughout the proposal form</td></tr>
<tr><td>(b) For options 1 or 2, list the grant numbers.</td><td colspan="2">→ insert relevant grant numbers</td></tr>
<tr><td>3.2 Duration of Proposal</td><td>Planned Start Date</td><td>To</td></tr>
<tr><td>Month and year:</td><td>1 October 2011</td><td>30 September 2016</td></tr>
</table>

3.3 Alignment to in-country cycles ONE PAGE MAXIMUM

Describe:

(a) how the proposal duration was selected in section 3.2 and how it contributes to alignment with the national fiscal cycle(s), programmatic reporting, or in-country program reviews; and
(b) the systems in place for regular national program reviews and evaluations (including Operations and Implementation research).

(a) how the proposal duration was selected in section 3.2 and how it contributes to alignment with the national fiscal cycle(s), programmatic reporting, or in-country program reviews;

The starting date of October 1 was chosen in order to be aligned with the Thai government fiscal year which begins on October 1. This will allow the government PRs and SRs, including the Ministry of Public Health and the Ministry of Social Development and Human Security, to integrate the implementation and monitoring of the GFATM-supported activities along with nationally budgeted activities. The results from the GFATM program can then be used to inform the various components of country's annual planning exercise.

(b) the systems in place for regular national program reviews and evaluations (including Operations and Implementation research).

Thailand has adopted the UNGASS reporting as the biennial review of the national response to HIV and AIDS. The next reporting period will be for the year 2010-2011, which will inform the planning of year 2 of the proposal. In addition, the monitoring and evaluation reports after 2 years of implementation of the Project will be included in the mid-term review of the next Five-year National AIDS Strategic Plan, covering the years 2012-2016.

3.4 Summary of Round 10 Proposal

Provide a summary of the HIV proposal.

Goal: Children affected by HIV and AIDS (CABA), and other vulnerable children living within communities of high HIV prevalence enjoy the same standards of social acceptance, personal development and quality of life as others.

This proposal, with support from the GFATM, aims to increase access to essential child-focused services, including those specifically related to HIV prevention, care and treatment, for vulnerable children up to the age of 18. This will be achieved through strengthened social protection mechanisms coordinated with existing health and community systems. Ministries of Public Health (MOPH) and Social Development and Human Security (MSDHS) will work in conjunction with existing community structures and civil society to more effectively design, implement, and monitor the delivery of high quality services (accessible, acceptable, non-discriminatory) through all delivery systems within the health, community, and social protection systems available in each province. This goal is consistent and aligned with Thailand's current *National Strategic Plan for Integration of HIV/AIDS Prevention and Alleviation, 2007-2011*.

Target populations: Target populations for this proposal include: (1) Children directly affected by HIV and AIDS (CABA), (2) Children made vulnerable by other causes and living in communities with high HIV prevalence, (3) Ethnic minority children who do not have Thai citizenship and are less able to access routine essential services. 29 out of a total of 76 provinces were selected for activities funded through this proposal based on above average: 1) HIV prevalence among ANC clients, 2) numbers of HIV-infected mothers, and 3) numbers of HIV infected children receiving ART. Provinces selected for inclusion in this proposal account for ~60% of the total number of HIV infected pregnant women and children on ART in Thailand. Approximately 50% of the estimated 225,474 vulnerable children, including 50% of the estimated 122,789 CABA are expected to benefit through implementation of this proposal over five years.

Implementation approach: Activities will start in all 29 provinces from Year 1. The number of sub-districts supported in each province, however, will be progressively increased over 5 years. At community level, the number of sub-districts selected for implementation is targeted at 15%, 30%, 50%, in year 1, 2 and 4-5 respectively.

Implementation Arrangements: The Project will be implemented by 2 Principal Recipients (PR):

- **PR1:** MOPH, Department of Disease Control (Government) with 4 sub-recipients (SRs) - (MOPH-Department of Health, health systems strengthening (HSS); MSDHS, social protection system strengthening (SPSS); PATH, technical support to HSS and SPSS; and Pact Thailand, M&E).
- **PR2:** AIDS ACCESS Foundation (non-governmental organization) with 8 SRs - (Raks Thai Foundation, community system strengthening; Thai Network of People living with HIV/AIDS Foundation, stigma reduction; Plan Thailand, implementation - Bangkok; World Vision Foundation Thailand, implementation - Central Region; AIDS Network Development Foundation, implementation - North and among ethnic minorities; Life Skill Development Foundation, implementation – North; Thai National AIDS Foundation, implementation – Northeast; Planned Parenthood Association Thailand, implementation – South.

Identified gaps: This proposal addresses several identified gaps associated with ensuring universal access to high-quality, gender-responsive services for CABA as well as other vulnerable children in Thailand. Key gaps addressed include: (1) weak implementation of social protection systems for children, and a lack of HIV-specific protections, (2) weak psychosocial support to complement effective and well-developed HIV clinical care, (3) limited follow up of HIV-exposed infants or inclusion of males within PMTCT programming, (4) stigma and discrimination faced by CABA, (5) weak programming for

adolescents with HIV, (6) high numbers of children in institutional care, (7) weak capacity for child-focused programming at community level associated with recent political decentralization, (8) and weak child-focused strategic information systems, resulting in decreased advocacy and programming effectiveness.

Objectives and corresponding activities: To achieve the goal stated above, four objectives have been identified, each with corresponding service delivery areas (SDA) and activities.

Objective 1: Strengthened and coordinated policies and systems integrating child-sensitive, HIV-related health care, community involvement, and social protection for quality service delivery.

SDA 1.1 - Health Systems Strengthening. Continuity of HIV-related care for children affected by HIV and AIDS and their families will be improved through implementation of a case management system spanning clinics and communities, and introduction of supportive supervision towards quality improvement in HIV health care, support and treatment for children. Psychosocial support will be integrated into healthcare services and support programs in all targeted provinces building on successful models already developed, decreasing stigma and discrimination, and yielding improved health outcomes.

SDA 1.2 - Community Systems Strengthening. Communities will be supported to be more responsive and effective in addressing needs of children affected by HIV and other vulnerable children. Management, service delivery, advocacy, and leadership skills will be strengthened. Child Action Groups (CAGS) will be formed at community level to facilitate child-focused programming including for CABA and other vulnerable groups of children.

SDA 1.3 – Social Protection Systems Strengthening. Social protection systems for children in Thailand are weak. This proposal aims to improve social protection for CABA and other vulnerable children through strengthened national and provincial management systems within the Ministry of Social Development and Human Security, development and implementation of a national strategy on alternative care for children who cannot be cared for by their biological parents, implementation of a more efficient, effective and targeted social transfer system, and strengthened legal protection and judicial systems related to issues of child protection, including implementation of Thailand's Child Protection Act (2003).

Objective 2: Equal and universal access to high quality, gender-responsive essential health and social services for CABA as well as for other vulnerable and marginalized children.

SDA 2.1 – Health system: Service delivery. Delivery of specific HIV-related health services will be strengthened with GFATM support, specifically male involvement within the context of PMTCT and broader reproductive health care, as well as early infant diagnosis. Young people living with HIV will be encouraged to provide psychosocial support to other young people living with HIV in areas ranging from adherence to addressing emerging sexuality. Student healthcare and support systems in basic education schools will be enhanced by incorporating psychosocial aspects related to HIV and sexuality in their guidelines and teacher training curricula.

SDA 2.2 – Community systems: Service delivery. At community level, capacity of parents and caretakers to provide psychosocial support for HIV-infected/affected children and adolescents will be strengthened, addressing a long-identified need by parents. Young people living with HIV will also benefit from increased access to sexuality/HIV education.

SDA 2.3 Social support: Service delivery. This proposal aims to increase household economic capacity for CABA and other vulnerable children with funds from MSDHS but through system strengthening supported by GFATM. Children of ethnic minorities who do not qualify for the MSDHS support because

their parents do not have Thai citizenship, will be supported by the Project. Reintegration of children from institutional care to live in a family environment through promotion of kinship and foster care will be supported.

Objective 3: Increased social acceptance and inclusion for adults and children infected and affected by HIV, as well as for those marginalized due to other causes

Interpersonal contact at community level, community education and public campaigns through local and national media will be implemented to increase public understanding and acceptance of PLHIV, as well as for those marginalized due to other causes.

SDA 3.1 PLHIV leadership in stigma reduction. The Thai Network of People living with HIV/AIDS (TNP+) will be supported through skills building activities to build its own capacity to reduce stigma associated with HIV in children as well as stigma from other causes.

SDA 3.2 Promoting stigma reduction by mass media. Media partners will be engaged in efforts towards more responsible reporting on CABA and other vulnerable children, and encouraged to feature positive stories on them on Thai public television.

Objective 4: Strengthened national, provincial, district and sub-district (including community) strategic information systems for improvement of services to vulnerable children

SDA 4.1 - HSS: Information system. A strengthened, unified M&E system focused on CABA and other vulnerable children will be developed which will contribute toward improved programming and policy development.

SDA 4.2 M&E capacity development and data use. M&E capacity, including data generation, analysis, and use will be strengthened at all levels.

SDA 4.3: Operational research, evaluation and selected studies. Relevant operational research and evaluations, consistent with national priorities will be undertaken to inform programming.

Expected outputs: This proposal aims to increase access for an estimated 112,738 vulnerable children in 29 provinces and 1,860 sub-districts. Approximately 61,395 of these vulnerable children are CABA, of whom approximately 2,117 are children living with HIV.

Proposed budget: US$ 42.08 million

4. PROGRAM DESCRIPTION

4.1 National program

Describe:

(a) current HIV national prevention, treatment, and care and support strategies;

(b) how these strategies respond comprehensively to current epidemiological situation in the country; and

(c) the improved HIV outcomes expected from implementation of these strategies.

(a) current HIV national prevention, treatment, and care and support strategies

Thailand's current strategies for HIV prevention, treatment, care and support are described in the *National Plan for Strategic and Integrated HIV/ AIDS Prevention and Alleviation 2007-2011* (*'The National Plan'*), which was developed through broad multi- sector collaboration and approved by the National AIDS Committee. *The National Plan* provides the framework for HIV and AIDS program/initiatives in Thailand of the public, civil society and private sectors.

The National Plan has two objectives:

1. To integrate strategies of HIV and AIDS prevention and alleviation into missions of organizations at all levels, and to promote collaboration across sectors;
2. To integrate strategies of prevention, care, treatment and impact reduction into service provision for all target population groups.

The National Plan identifies four strategies :

Strategy 1: Management to integrate the HIV and AIDS response into all sectors. The response to HIV and AIDS is to be integrated into policies and programs at the national, provincial and local levels of government;

Strategy 2: Integration of prevention, care, treatment and impact mitigation according to target populations. Priority target groups include husbands and wives or discordant couples, men who have sex with men, sex workers and their clients, drug users, children and youths and other groups including prison inmates, migrant labors, Thai laborers abroad, laborers in the workplaces, ethnic minorities and undocumented residents, displaced persons in temporary shelters;

Strategy 3: Protection of HIV and AIDS-related rights; and

Strategy 4: Monitoring, evaluation, research and development of knowledge for HIV and AIDS prevention and alleviation

The *National Plan* identifies 2 specific measures for children infected and affected by HIV and AIDS (CABA) (up to 18 years old) as groups with special needs. The measures include:

1. Develop care systems for children affected by HIV and AIDS.
2. Develop and promote the roles and capacity of children, families, communities and society in the prevention and alleviation of problems related to children affected by HIV and AIDS.

(b)how these strategies respond comprehensively to the current epidemiological situation in the country

The current epidemiological situation summarized in the UNGASS Country Progress Report, January 2008 – December 2009, concludes that apart from the reduction of HIV prevalence among pregnant women and new male military recruits, there is evidence that there continues to be increasing rates of HIV infection among specific groups, i.e. adolescents, IDUs, MSM and non venue-based sex workers.

The Asian Epidemic Model (AEM) analysis determined that during 2007- 2011 the proportion of new cases by the risk factor women infected by their husband or steady partner and men infected sexually by another man account for more new infections than other mode of transmission..

The priority target population groups identified in the *National Plan* (strategy 2) are still relevant to the current epidemiological situation of the country. Thailand's ART program, with support from the national health security program and the GFATM, has greatly improved access to ARV drugs so that at

least 200,000 PLHIV are being treated. Nevertheless, by analyzing at the projections data for surviving PLHIVs, plus the newly infected, and holding trends constant from 2005, it is estimated that there were a half million PLHIV in Thailand in 2009, with 281,139 progressing to a stage requiring ART.

Strategy 2: Integration of prevention, care, treatment and impact mitigation for each target population is still consistent with the current epidemiological situation of the country. In parallel with the measures to reduce new HIV infection cases, VCT to be strengthened for priority target populations to ensure access to early care and treatment for those who are infected. The strategy promotes: 1) greater holistic care in terms of physical, psychological, social, spiritual and financial services are provided to PLHIV; and 2) PLHIV and affected families living meaningfully as part of Thai society and actively participating in the development of their own communities.

Given the context of decentralization of the country, specific measures under strategy 1, i.e. integration of AIDS prevention and alleviation at the provincial and local levels leading to local ownership will bring about the sustainability of the response to HIV and AIDS in the locality. The *National Plan* assumes that local administrative organizations will initiate policies on prevention and alleviation of HIV and AIDS and other related problems.

(c) the improved HIV outcomes expected from implementation of these strategies

The National Plan has 3 goals:

1. People have the appropriate knowledge and practice safe behaviors to protect themselves and their families from HIV infection and transmission.
2. PLHIV and those who are affected by AIDS have a good quality of life and are able to live together peacefully and enjoy the full benefits of society.
3. Families and communities have a safe environment that supports the prevention of infection, protection from stigma and discrimination and enables those living with HIV and AIDS and those without, to live together peacefully in their communities; participating as one in most aspects of AIDS prevention and alleviation

The National Plan sets three ambitious targets which focus the efforts to respond to the HIV epidemics in Thailand by 2011:

1) Incidence of HIV will be reduced by 50%;
2) Universal access to treatment with ARV will be achieved for those who meet the criteria; and
3) At least 80% of those infected or affected by HIV in need for support are able to access appropriate social services.

4.2 Epidemiological profile of target populations

(a) Describe the current epidemiological profile of the target populations, and how this profile is changing with respect to HIV.

(a) Describe the current epidemiological profile of the target populations, and how this profile is changing with respect to HIV.

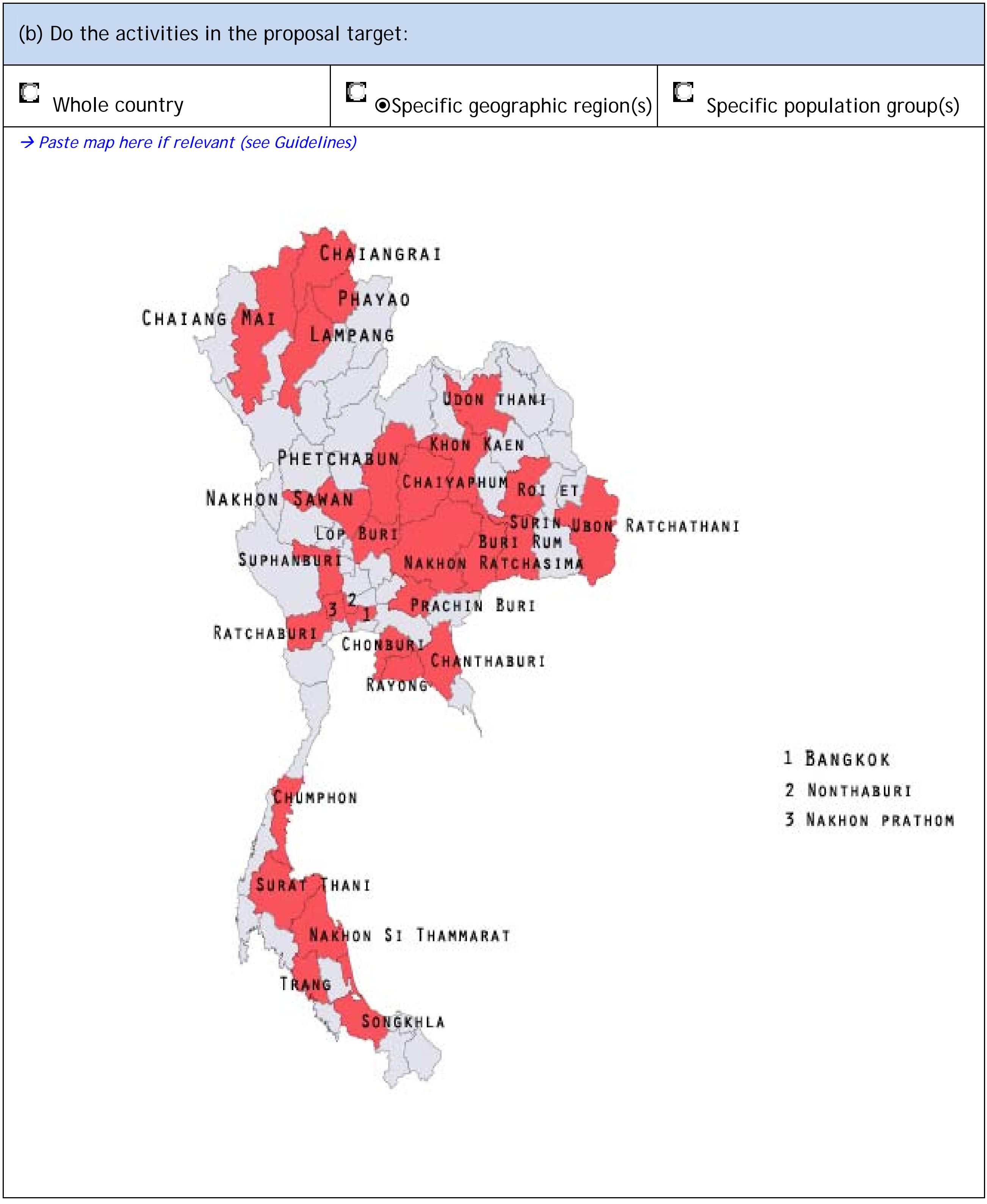
Thailand has been severely impacted by the HIV and AIDS epidemics in the last three decades. HIV infections started among injecting drug users, followed by sex workers and subsequently reached the general population via the clients of the sex workers. The epidemics have been focused on women and men of reproductive age and their children through the main driving force -unsafe sex. The first pediatric AIDS with HIV perinatal transmission was reported in 1988

Although the HIV prevalence among pregnant women dropped from the 1995 peak of 2.2% to 0.72% in 2009 and there is high coverage of PMTCT services, there still remain a large population of children affected by HIV and AIDS. Using the Asian Epidemic Model (AEM), in 2009 the estimated number of HIV negative children in the age range of 0-17 years born to HIV infected mothers was 321,792. Sixty four percent of them were children aged between 10-17 years and 36% were 0-9 years old.

The national program on HIV and AIDS prevention, including PMTCT, has scaled up considerably and has reduced the number of orphans that otherwise would have been born to HIV+ mothers. But the long history of the HIV pandemic in Thailand has led to current number of orphans due to HIV and AIDS. Using AEM again, it is estimated that in 2009 there were 301,865 orphans due to HIV/AIDS who were 0-17 years old and who had lost at least one parent to AIDS. Of those, 91,706 were 0-9 years old. It also was estimated that there were 853,456 orphans due to all causes, as extrapolated from the Multiple Indicator Cluster Surveys in 2006. These data indicate that about 35.4% of all orphans in the country have lost at least one parent to complications of AIDS.

The AEM also estimates the number of children and adolescents aged 0-19 years living with HIV in 2009 was 26,975. 46% of them are adolescents (15-19 years old), which need support in the transition from adolescent to adult life. 30% are in the 10 to 14 year age range which needs preparation for sexual relationships. 15% are in early childhood (5-9 years) and need to know their sero status and require more psychosocial support. 8% are under 5 and need proper care for growth and development. Regarding gender, male to female ratio in every age group is around 1:1, except in the adolescent group the ratio is 1: 1.3.

Using the SPECTRUM Model, the number of HIV-infected children needing ART in 2008 and 2009 was estimated to be 9,284 and 9,450 respectively. According to the National ART monitoring system, 7,990 and 8,076 were reported as receiving ART at the end of 2008 and 2009. These data indicate that the ART coverage of eligible HIV+ children was 86.1% in 2008 and 85.5% in 2009.



(b) Do the activities in the proposal target:		
☐ Whole country	☐ ⦿Specific geographic region(s)	☐ Specific population group(s)

→ Paste map here if relevant (see Guidelines)

(c) Size of target population(s) → *If national data is disaggregated differently then type over the categories proposed*			
Population Groups	Population Size	Source of Data	Year of Estimate
Total country population (all ages)	63,525,062	Department of Provincial Administration ,MOI	2009
Females > 25 years	20,917,389	Department of Provincial Administration ,MOI	2009
Males > 25	19,321,242	Department of Provincial Administration ,MOI	2009
Females 20-24	2,259,357	Department of Provincial Administration ,MOI	2009
Males 20-24	2,314,200	Department of Provincial Administration ,MOI	2009
Females 15-19	2,344,720	Department of Provincial Administration ,MOI	2009
Males 15-19	2,457,126	Department of Provincial Administration ,MOI	2009
Females 10 – 14 years	2,275,576	Department of Provincial Administration ,MOI	2009
Males 10 – 14 years	2,399,877	Department of Provincial Administration ,MOI	2009
Females 5-9 years	1,953,530	Department of Provincial Administration ,MOI	2009
Males 5-9	2,064,433	Department of Provincial Administration ,MOI	2009
Females 0-4	1,886,183	Department of Provincial Administration ,MOI	2009
Males 0-4	2,000,931	Department of Provincial Administration ,MOI	2009
Other: Females –non Thai nationality	180,091	Department of Provincial Administration ,MOI	2009
Males – non Thai nationality	209,564	Department of Provincial Administration ,MOI	2009
HIV negative Children 0-17 years born to HIV infected	321,792	Thailand AEM Projection May 009 revision	2009

(c) Size of target population(s) → *If national data is disaggregated differently then type over the categories proposed*			
Population Groups	Population Size	Source of Data	Year of Estimate
mothers			
HIV negative Children 0-9 years born to HIV infected mothers	116,044	Thailand AEM Projection May 009 revision	2009
HIV negative Children 10-17 years born to HIV infected mothers	205,788	Thailand AEM Projection May 009 revision	2009
Orphans due to AIDS (0-17 years)	301,865	Thailand AEM Projection May 009 revision	2009
Orphans due to AIDS (0 - 9years)	91,706	Thailand AEM Projection May 009 revision	2009
Orphans due to all causes	853,456	Multiple indicator Cluster Surveys (MICS)	2006

(d) HIV epidemiology of target population(s) → *If data is disaggregated differently then type other the categories suggested and enter your own population group*			
Population Groups	Estimated Number	Source of Data	Year of Estimate
Number of people living with HIV *(all ages)*	513,914	Thailand AEM projection 2005	2009
Females living with HIV > 25 years	174,033	Thailand AEM projection 2005	2009
Males living with HIV > 25 years	273,456	Thailand AEM projection 2005	2009
Females living with HIV 20 – 24 years	20,096	Thailand AEM projection 2005	2009
Males living with HIV 20 – 24 years	19,353	Thailand AEM projection 2005	2009
Females living with HIV 15 – 19 years	6,915	Thailand AEM projection 2005	2009
Males living with HIV 15 – 19 years	5,469	Thailand AEM projection 2005	2009
Pregnant females living with HIV >25 years	4,619	Thailand AEM projection 2005	2009
Pregnant females living with HIV 20-24 years	1,131	Thailand AEM projection 2005	2009

Pregnant females living with HIV 15-19 years	347	Thailand AEM projection 2005	2009
Females 10–14 years living with HIV	4,040	Thailand AEM projection 2005	2009
Males 10-14 years living with HIV	4,136	Thailand AEM projection 2005	2009
Females 5-9 years living with HIV	2,059	Thailand AEM projection 2005	2009
Males 5-9 years living with HIV	2,116	Thailand AEM projection 2005	2009
Females 0–4 years living with HIV	1,101	Thailand AEM projection 2005	2009
Males 0-4 years living with HIV	1,139	Thailand AEM projection 2005	2009

4.3 Major constraints and gaps in disease, health, and community systems

4.3.1 HIV program

(a) the main weaknesses in the implementation of current HIV strategies

Resources

Resources: The National AIDS Spending Assessment (NASA) indicates that in pursuit of the universal ART policy adopted by the Royal Thai Government in 2003, most of the HIV AND AIDS budget is being spent for care and treatment. Expenditures earmarked for children affected by AIDS (CABA) were consequently reduced to 1%.

Decentralization

Recent government reforms, especially the decentralization of authority and budgeting for direct implementation of many public services to the Local Administrative Organizations (LOAs), has led to the disappearance or reduction of HIV and AIDS interventions in many locations where they are sorely needed. The Community Health Fund, provided from the NHSO as a match to the budget from the TAOs, is rarely allocated to HIV programs.

Program Monitoring and Evaluation of Services to Children Affected by HIV and AIDS (CABA)

The January 2009 Report on Gap Analysis on Young Children Affected by HIV and AIDS in Thailand identified the lack of effective monitoring and evaluation systems as a serious obstacle to effective responses to their needs. The program monitoring and evaluation systems for CABA are fragmented and of little value. A national system does not exist for this population so information is available only at the project level. A major impediment to the development of more effective monitoring and evaluation systems is that staff in neither the government agencies nor the NGOs has the technical skills to collect and utilize the appropriate information.

(b) *existing gaps and inequities in the delivery of services to the target populations*

Limited and inadequate Support to PLHIV and Affected Families

The budget for support of an HIV+ child (or adult) is only 500 Baht/month. This is inadequate for families facing economic difficulties. Ethnic PLHIVs are not eligible even for this small cash transfer.

Stigma and Discrimination

The December 2009 report of the Stigma-Discrimination Index Survey found that stigma still is still a significant problem in Thailand. Out of 233 PLHIVs interviewed, 34.3% indicated that they were restricted from participating in community activities and 32.2% indicated that they had lost their jobs because of their HIV status. Stigma and discrimination faced by CABA in school was highlighted as an important issue.

Protection of Children's Rights

Policies and Programs which protect the basic rights of children are not functional in Thailand. As a result, CABA and other vulnerable and marginalized children may be subjected to abuse and deprived of their fundamental rights without recourse.

(c) how these weaknesses affect achievement of planned national HIV outcomes

Inadequate information on the welfare of CABA, orphans and other vulnerable and marginalized children, and programs intended to address their needs has resulted in inadequate policies and services for them. As noted above, stigma remains as a barrier for accessing care and support services and the absence of provisions for the protection of their rights results in them being neglected and silenced.

The available evidence provides cause for concern:

- The MICs in 2006 found that only 21% of OVC received support from public programs;
- Attendance at pre-primary school was 48% among OVC and 68% in non-OVC.

Chronic malnutrition is 16% in orphans, 15% in vulnerable children and 12% in non-OVC.

4.3.2 Health Systems

Describe the main weaknesses of and/or gaps in health systems that affect HIV outcomes.

Psychosocial Support in Health Care Service and Support Programs: Thailand provides quality HIV and AIDS care and support for HIV+ children at the provincial level and is in the process of decentralizing this responsibility o the district hospitals. However, the focus of services is mainly on the delivery of ART with little psychosocial support service. Disclosure counseling models for HIV-infected children have been developed and this service is being implemented. However, other important psychosocial support i.e. positive prevention, ART adherence counseling, and capacity building for providers for HIV-infected youth are lacking. The management of effective care in the transition period between adolescence and adulthood is another major unaddressed challenge. Counseling services for children, where they do exist, tend to be generic and often do not consider gender differences.

Continuity of HIV Care: Although the coverage of PMTCT services is high, an evaluation conducted in 2009 found that only 56% of parents of exposed children received information on their child's serostatus. This affects timely initiation of care and treatment for the infected children. A national PMTCT evaluation conducted in 2008 found that only 56% of infants born to HIV-infected mothers received information on their serostatus. This poses a major barrier to a timely initiation of care and treatment for the HIV-infected babies. A major deficiency is limited capability of hospital staff to actively follow-up children. In addition, there is no formal linkage among relevant services including MCH, PMTCT, postpartum care, and ART clinics.

Quality of counseling service and male involvement: Due to constraints in time and human resources, counseling at ANC has been less effective than it could be, and an inability to actively engage men in PMTCT has resulted in HIV infection for women and children in subsequent pregnancies

Health Promotion for Growth and Neuro-Development: HIV infected/affected children are more susceptible to growth stunting, neuro-developmental impairment and emotional, behavioral, and social problems. Adequate developmental screening and stimulation services are offered only in some of the regional and provincial hospitals. A survey performed in 2006, before any quality improvement intervention by TUC, using pediatric HIVQUAL in 5 tertiary care centers, revealed that about 75% of HIV-infected children received developmental screening by history taking and physical examination at least onceຢ during the review period (1 year)ຢ but only 4% of those with abnormal development received appropriate intervention. According to the pediatric HIVQUAL performance data 2008,ຢ proportion of HIV-infected children receiving developmental screening inຢ 20 tertiary care hospitals and 24 community hospitals wereຢ 58% and 89%, respectively. Of these,ຢ 96% and 43% of children with abnormal development in tertiary care hospitals and community hospitals, respectively,ຢ received appropriateຢ management. This may be due to limited number of pediatrician and developmental experts who can provide appropriate management for children with abnormal development.

Quality of Services in Orphanages and Day Care Centers: Despite the formal policies that have been developed for the protection of children in orphanages and day care centers, there is inadequate monitoring of the implementation of these policies, and there still exist cases of rights violation and exploitation of children in institutions.

Promotion of Alternative Care for CABA: The MSDHS has a policy to promote foster and kinship care, but incentives for being foster parents are not adequate. The support from the MSDHS staff to foster parents and kinship guardians, particularly in relationship to psychosocial care, gender issues and the rights of children also is weak.

Sexual Exploitation: There are no specific laws to address the sexual exploitation of female youth and children, and, as in most countries, the extent of the problem is unknown. However, international experience has documented greater vulnerability of female children in foster care or adopted families to sexual abuse. Protection for children, both male and female, is limited but a few provincial hospitals have crisis center services for women and girls who are victims of violence. . The need for early recognition of child abuse and its appropriate management is definitely needed. Currently, such service does exist at only the provincial hospital level, but does not exist at the district hospital and by no mean

linked to any community mechanism.

4.3.3 Community Systems

Describe the main weaknesses of and/or gaps in community systems that affect HIV outcomes.

Skills in Providing Care and Support to CABA

Civil society has many important roles in energizing community activities. However, to provide psychosocial care and support to CABA and vulnerable children it is necessary for community personnel and volunteers to have a specific set of knowledge, attitudes and skills. In most local communities in Thailand these cadre need more understanding of issues specific to age, gender and HIV serostatus, further development of attitudes re. acceptance of the HIV+ child and skills in delivering services that respond to specific needs of children and families.

Child Rights Protection and Child Abuse Management

Community-based organizations, even community leaders and elected officials, are often uninformed about child rights protection issues. They often are neither sensitive to the issues of child abuse nor aware of appropriate responses when violations are apparent.

Community Networks, Linkages, Partnerships and Coordination

Various organizations, including GOs and NGOs, are working in the communities on their respective missions and projects. Services for the individual child are mostly separated and not responding to the child's needs in a holistic way. Duplication of support to the same child is common while other children's needs are ignored. Linkages have not been established between services in the community and government facilities. The referral mechanisms between community-based services and facilities are at different levels for different services, i.e. health, economic support, child right protection, etc. In addition, the follow-up and outreach services are still ineffective. Thus, many children discontinued services and efforts to track them down are frustrated by problems of stigma.

Mobilization of Local Resources

The Tambon Administration Organizations (TAOs), responsible for the local budget allocation for community development, usually have neither a clear policy nor action plans to deal with children affected by HIV/AIDS and other children at risk. There is no systematic collection of data for analysis and developing action plans. Subsequently, most of the implementation is in response to instructions sent down from the national level.

Roles of PLHIV and YLHIV and Affected by HIV for the community

The TNP+ have been effective in advocacy, mostly for the right to access services by PLHIV. Understanding stigma from their own experiences is not enough to reduce stigma in the community. In addition, the members of TNP+ have moved their work toward using their potential and expanded spheres of influence in the community. The inclusion of PLHIV and YLHIV and those affected by HIV in working for all vulnerable children in the community would be the crucial steps for stigma reduction as well as inspiring PLHIV and YLHIV and affected by HIV for their continuing work for the community.

Monitoring and evaluation and using evidence for planning

The absence of a useful documentation system has resulted in the community being unable to develop and evaluate program implementation. This reflects lack of expertise and human resources in the community.

4.3.4 Efforts to resolve weaknesses and gaps

Describe what is being done, and by whom, to respond to health and community system weaknesses and gaps that affect HIV outcomes, as outlined in sections 4.3.2 and 4.3.3.

Psychosocial support in health care service and support program, Skills of CSO in providing care and support to CABA

The DOH has piloted the initiatives to include male partner to participate in ANC and couple counseling to help the woman disclose her serostatus and encourage the man to be tested so that he can receive treatment as appropriate. There are new challenges in positive prevention, counseling for adolescent PLHIV, transition from adolescence care to adult care, and providing on-going care for infected mothers and their newborns. Under the R1-RCC, PLHIVs have been empowered to provide socio-psycho services. Yet, the emphasis is still given to working with children living HIV/AIDS who seek services from the ARV clinics.

Continuity of HIV-related care and promotion of growth and neuro-development

The DDC, in collaboration with the NHSO and TUC, has expanded the pediatric care and ART services to district hospitals through building human resource capacity of local hospital health care providers and staff of civil societies. The model is still limited to only some sites and not widely implemented. Meanwhile growth and neuro-development of CABA is still overlooked.

Community networks, linkages, partnership and coordination

GOs and community civil society organizations have developed pilot service program for children in community. It aims to respond comprehensively to the needs of a child on a sustainable basis and to reach out to children affected by HIV/AIDS and other children at risk.

Quality of services of orphanages /day care centers and promotion of alternative care for CABA

The MSDHS has already standard of orphanages and day care centers and is developing policy and strategies for alternative care for CABA and vulnerable children. The challenge is the translation of policy and legislation at the national level into practice at the local level.

Stigma and discrimination, child rights protection, and roles of PLHIV and YLHIV and affected by HIV for the community

The Thai NGOs Coalition on AIDS launched the report on policy and implementation on AIDS-related rights protection, and the TNP+ launched the report of the stigma index survey with recommendation for the policy level. New approach of the inclusion of PLHIV and YLHIV and affected by HIV is being considered. For children, given the existence of a committee that monitors the rights of the child under the MSDHS, the efficient measures on child rights protection are still to be improved as well as the monitoring at the community level.

Decentralization, mobilization of local resources. limited and inadequate support to PLHIV

The MOI has developed standard of HIV and AIDS implementation for local administrative organizations (LOAs). However, it is still not HIV-sensitive guidance. Under the R1-RCC, coordinating mechanisms have been developed to link up AIDS work at the Tambon and provincial levels in 43 provinces. Child services are still one of their weaknesses. Various initiatives have been implemented to seek effective approaches to facilitate the LOAs.

Monitoring system

The National AIDS Management Center (NAMc), in collaboration with organizations from various sectors is developing the national M&E plan and system. The national technical working group on M&E for care of children and families affected by HIV and AID has just been established. The DOH has been developing monitoring system on PMTCT linked to children born to HIV infected mothers, meanwhile UNICEF and MSDHS support TAOs to develop community child database in areas affected by the tsunami.

4.4 Proposal strategy

Complete this version of section 4.4.1 if the applicant selected option 2 or 3 in section 3.1 of the Proposal Form

Option 2 = Transition to a single stream of funding during grant negotiation
Option 3 = No transition to a single stream of funding in Round 10

CLARIFIED SECTION 4.4.1 -the applicant's response was transferred from 4.4 for Option 1 to 4.4 for Option 2&3.

4.4.1 Interventions

→ This section should be completed in parallel with the Performance Framework and detailed budget and work plan

Describe the objectives, service delivery areas (SDA), and activities of the proposal. **The description must be organized in that exact order and the numbering system must match the Performance Framework, detailed budget and work plan.**

The description must reference:
(a) who will implement each area of activity (e.g. Principal Recipient, Sub-recipient or other implementer); and
(b) the targeted population(s).

Goal: Children affected by HIV and AIDS, as well as other vulnerable and marginalized children living within communities of high prevalence enjoy the same standards of social acceptance, personal development and quality of life as others.

This proposal aims to increase access to essential child-focused, gender-responsive services, including those specifically related to HIV prevention, care and treatment, for marginalized and vulnerable children up to the age of 18. It is envisioned that this will be achieved through strengthened social protection mechanisms coordinated with existing health and community systems. Ministries of Public Health (MOPH) and Social Development and Human Security (MSDHS) will work in conjunction with existing community structures and civil society to more effectively design, implement, and monitor the delivery of high quality services (accessible, acceptable, non-discriminatory) through all delivery systems within the health, community, and social protection systems available in each province. This goal is consistent with Thailand's current National Strategic Plan for Integration of HIV Prevention and Alleviation, 2007-2011.

Target Populations: Target populations for the proposal include: (1) *Children directly affected by HIV/AIDS (CABA)*, including HIV infected children and adolescents (0-18 years of age), HIV-exposed infants (0-2years of age), Children impacted by HIV (0-18 years of age) as a result of one or both parents being infected, having a member of the household infected, or being a child of a most-at-risk person (MARP); (2) Children aged 0-18 who marginalized or made vulnerable by other causes and living in communities with high HIV prevalence; and (3) Ethnic minority children who do not have Thai citizenship and are therefore less able to access routine essential services. 29 out of a total of 76 provinces were selected for activities funded through this proposal based on above average 1) HIV prevalence among ANC clients, 2) numbers of HIV-infected mothers, and 3) numbers of HIV infected children receiving ART. Regional equity was considered and the selected high-prevalence provinces are from all 4 regions of the country as well as Bangkok. Provinces selected for inclusion in this proposal account for ~60% of the total number of HIV infected pregnant women and children on ART in Thailand.

Implementation approach: To ensure sustained improved access for CABA, systemic improvements in health, community and social protection will be supported which will in turn extend benefits to other vulnerable children. Activities will start in all 29 provinces from Year 1. The number of sub-districts supported in each province, however, will be progressively increased over 5 years. At community level,

the number of sub-districts selected for implementation is targeted at 15%, 30%, 50%, in year 1, 2 and 4-5 respectively.

Implementation Arrangements: The Project will be implemented by 2 Principal Recipients (PR):
- **PR1:** MOPH, Department of Disease Control (Government) with 4 sub-recipients (SRs) - (MOPH – Department of Health, health systems strengthening (HSS); MSDHS, social protection system strengthening (SPSS); PATH, technical support to HSS and SPSS; and PACT, M&E).
- **PR2:** AIDS Access Foundation (non-governmental organization) with 8 SRs - (Raks Thai Foundation, community system strengthening; Thai Network PLHIV Foundation, stigma reduction; PLAN, implementation – Bangkok; World Vision, implementation – Central Region; AIDSNet Foundation, implementation – North and among ethnic minorities; Life Skill Development Foundation, implementation – North; Thai National AIDS Foundation, implementation – Northeast; Planned Parenthood Association Thailand, implementation – South.

PR-DDC will be responsible for facilitating joint strategic management between the 2 PRs.

Objective 1: Strengthened and coordinated policies and systems integrating child-sensitive, HIV-related health care, community involvement, and social protection for quality service delivery.

SDA 1.1 - Health Systems Strengthening

1.1.1: Ensure continuity of HIV-related care for children affected by HIV/AIDS and their families across the health-community continuum.

1.1.1.1: Implementation of a case management system to support continuity of care. A case management system will be implemented linking providers from hospitals, health centers, the community and civil society. Training modules will be developed and training provided to healthcare workers and community-based providers. Case management tools will be developed, field tested, and implemented. Existing comprehensive care centers (CCC) will function as the link between clinics and community. (PR-DDC; SRs-DOH, PATH)

1.1.1.2: Supportive supervision for quality improvement. Teams representing health, social development, community, and civil society will be formed under the auspices of provincial health promotion centers with input from regional health promotion centers to conduct supportive supervision visits to community health centers to ensure that tools facilitating continuity of care are appropriately used and that services meet minimum requirements. Health clinics will be provided assistance to improve quality of services they provide as needed. (PR-DDC; SR-DOH)

1.1.2: Integrate psychosocial support into health care services and support programs.

1.1.2.1: Training in psychosocial support. Training modules and informational material will be developed to support healthcare workers provide more effective age-appropriate and gender-specific psychosocial support to children infected/affected by HIV. Healthcare workers will be trained to assist children and adolescents come to terms with their HIV status, successfully adhere to medications, and determine how to disclose their status in appropriate situations including in the context of positive prevention and reproductive health. Modules will also be developed to guide healthcare workers supporting adolescents as they transition from pediatric to adult care. Successful approaches already developed and piloted in 4 provinces in Thailand will be expanded to target provinces. Support groups for children infected with or affected by HIV, including art therapy sessions, will be linked to Youth Friendly Services funded through the R1-RCC program. Capacity will be built within communities and governmental institutions such as the MOSDHS to take ownership for these activities in the future. (PR-DDC; SRs-DOH. MSDHS, PATH)

1.1.2.2: Healthcare and support in schools: Student healthcare and support systems will be enhanced by incorporating psychosocial aspects related to HIV and sexuality in their guidelines and teacher training curricula. (PR-DDC; SR-PATH)

1.1.3: Build capacity for monitoring and supporting children's emotional and neurological development.

To increase early detection of developmental delays among HIV-infected children and provide appropriate management, a user-friendly, gender/age-responsive child development service package will be developed with tools for screening and stimulation for children aged 0-18 years old. This will be accomplished following a needs assessment, consultations with national experts, and field testing of developed tools. The tools will be tailored for use by providers at district hospitals, by trained community child care workers, and by caregivers of children in alternative care. The package will be rolled-out utilizing National Health Security Office (NHSO) resources for children at district hospitals, health centers, and alternative care settings. (PR-DDC; SRs-DOH, PATH)

1.1.4: Improve quality of institutional care. While it is official policy for as many orphaned or abandoned children as possible to remain in the care of extended families and communities, the fact remains that many children have no other option than institutional care. While the Government works to address this issue, there is a need to ensure that children with or without HIV and residing in institutions receive better quality care. To raise the quality of care, the current standard of care will be updated to be consistent with UN alternative care guidance and will also include guidance on HIV-specific services and child development as well as aspects related to psychosocial support and basic clinical care. A self-assessment tool based on the revised standards of alternative care will also be developed and rolled out to assist institutions assess and improve the quality of care they provide. (PR-DDC; SRs-MSDHS, PATH)

SDA 1.2 – Community Systems Strengthening

1.2.1: Build skills for service delivery, advocacy and leadership among community-based organizations.

1.2.1.1: Mobilize communities to form Child Action Groups (CAG). CAGs are groups comprising PLHIV as well as teachers, health care workers, community leaders, members of faith-based organizations, and other members of civil society who will be formed at Tambon level to both plan for and provide community-based, child-focused services to CABA and other vulnerable children. CAGs will be linked to local resources and local administrative organizations (TAOs). (PR-ACCESS; SRs-RTF, PLAN, WVFT, AIDSNet, LSDF, TNAF, PPAT)

1.2.1.2: Organizational capacity assessments and strategic planning. CAGS and other community groups will be supported to conduct organizational capacity assessments, mapping of community health and social support services and their accessibility to end users including identification of populations of children most at risk and identification of obstacles to accessing and using services, and build capacity for long term strategic planning, management, and scale-up. Workshops will be held bi-annually at provincial level to share successful approaches in programming for CABA and other vulnerable children. (PR-ACCESS; SRs-RTF, PLAN, WVFT, AIDSNet, LSDF, TNAF, PPAT)

1.2.1.3: Resource mobilization. CAGS will be coached to use knowledge learned and new skills to advocate for additional resources for CABA and other vulnerable children to sustain child-focused programming. (PR-ACCESS; SRs-RTF, PLAN, WVFT, AIDSNet, LSDF, TNAF, PPAT)

1.2.2: Coordination of Child Action Groups. Regular meetings will be held among CAG members in each tambon for purposes of planning, experience sharing, and discussing opportunities for advocacy. (PR-ACCESS; SRs-PLAN, WVFT, AIDSNet, LSDF, TNAF, PPAT)

SDA 1.3 – Social Protection Systems Strengthening

1.3.1: Develop and support implementation of a national strategy on alternative care. A national policy on alternative care for children, in particular CABA, is needed at national level to inform programming at national, provincial, and district levels. An assessment of current practices of providing care for children will be undertaken followed by development of legally binding national guidelines and a manual of operations and standards through a national consultative series of meetings. Adopted standards will facilitate increasing budgetary allocations for social welfare, alternative care and protective services. (PR-DDC; SR-MSDHS)

1.3.2: Strengthen skills for effective promotion and management of kinship and foster care systems. Mechanisms will be developed for improved administration and management of kinship and foster care, by 1) strengthening capacity of Dept. of Social Development and Welfare (DSDW) in SDHS to function as a central agency for the provision of family based care with the responsibilities to promote, support, monitor, supervise, accredit and manage the provision of family based care; 2) Establishing provincial and local mechanisms in all provinces; 3) Develop an in-service training package for government officials and NGO staff who provide and manage family based care; 4) Develop monitoring and evaluation systems to ensure that care by kinship and foster families are up to nationally approved standards; and 5) reviewing current laws and regulations regarding kinship care and foster care to ensure they are in line with international standards and helping support the improvement of the kinship and foster care system. (PR-DDC; SR-MSDHS)

1.3.3: Strengthen the social transfer system to make it more efficient, effective, and targeted. A review will be conducted of existing mechanisms to identify vulnerable families including those affected by HIV and AIDS in need of social assistance to meet minimum needs, assess levels of support and their capacity to achieve desired outcomes of poverty alleviation, and recommend changes to the current system. Action on recommendations will be supported to ensure greater social protection for CABA and other vulnerable children. (PR-DDC; SR-MSDHS; PR-ACCESS, SRs- PLAN, WVFT, AIDSNet, LSDF, TNAF, PPAT)

1.3.4: Install coordinated management mechanisms at national, provincial, and district levels linking child protection and HIV. A national task force will be created agree upon coordinated management mechanisms associated with implementation of child protection in the context of HIV. Communication channels between the two sectors will be defined. A database of organizations involved in child protection and/or HIV will be compiled to assist in coordination activities. At provincial levels, joint team meetings will be held to plan for a coordinated implementation approach. Regular forums for exchange of lessons learned across provinces will be held. (PR-DDC; SR-MSDHS)

1.3.5: Strengthen legal protection and judicial systems related to issues of child protection.

1.3.5.1: Strengthen the implementation of the Child Protection Act at Provincial and Community level. Children infected or affected by HIV are at heightened risk of abuse or neglect (e.g. disinheritance, stigma, child labor), and children vulnerable to any form of abuse can be at greater risk of HIV infection. Provincial Child Protection Committees and other concerned professionals (e.g. teachers and police), will be trained in monitoring, reporting and responding to children in need of assistance and protection. Community volunteers and members of Family Development Centers will also be trained on the Child Protection Act and its implications. (PR-DDC; SR-MSDHS)

1.3.5.2: Strengthen, develop, and implement legislation and enforcement policies on child labor, trafficking, sexual abuse, and exploitation that are in line with international standards. At the provincial level, where the courts are located, there is insufficient understanding of the human and legal rights of orphans and HIV infected/affected children. The provincial justice system will be made more child sensitive, by making it more aware of judicial precedents and best practices in enforcing existing laws (e.g. the 1998 Labour Protection Act and the 2003 Child Protection Act), in order to provide a safe environment and sensitive procedures for children and parents who experience stigma, abuse and exploitation including due to HIV/AIDS. (PR-DDC; SR-MSDHS)

1.3.5.3: Implement community-based monitoring systems. Capacity of teachers, health and community workers, and youth organizations will be developed to identify children at risk, report on cases of abuse and exploitation, and provide referrals through development of informational guides and training. (PR-DDC; SR-MSDHS)

Objective 2: Equal and universal access to high quality, gender-responsive essential health and social services for CABA as well as for other vulnerable and marginalized children.

SDA 2.1 – Health system: Service delivery

2.1.1: Strengthen male involvement within the context of PMTCT and broader reproductive health care. HIV testing of partners of pregnant women will be promoted by strengthening skills about 'couple counseling'. Health service providers at all levels will be trained in competency-based methods. In addition, BCC material will be developed in several languages to encourage couples testing and counseling in the context of ANC. (PR-DDC; SRs-DOH, PATH)

2.1.2: Improve virological testing (EID) uptake for HIV exposed infants. A national review of bottlenecks associated with EID will be conducted with development of recommendations for program strengthening. Standard operating procedures will be updated. A tracking system/ database will be put in place, with improved referral between provinces. (PR-DDC; SR-DOH)

2.1.3: Monitor and support children's growth and neurodevelopment. To increase early detection of developmental delays in children at risk and provide appropriate management, child development monitoring will be introduced at district hospitals, community day care centers, institutional care settings, and during home visits. Stimulation activities will be provided appropriately with referral to higher level facilities as needed. (PR-DDC; SRs-DOH, MSDHS, PATH)

2.1.4: Promote positive role models and social participation of young people living with HIV (YPLHIV). Stigma related to HIV prevents or significantly limits involvement of YPLHIV in social activities. Initial work in a few provinces by the 2010 Red Ribbon Award winning Youth Volunteer Group in facilitating the role of YPLHIV as ARV adherence support counselors to younger children and in conducting HIV prevention education in public places, will be expanded to all targeted provinces. (PR-ACCESS; SRs-PLAN, WVFT, AIDSNet, LSDF, TNAF, PPAT)

SDA 2.2 – Community systems: Service delivery

2.2.1: Build capacity of parents and caregivers to provide psychosocial support for HIV-infected/affected children and adolescents and other vulnerable children. Most parents and in particular parents and caregivers of HIV infected/affected children are not well prepared to address the multiple challenges for these children including physical and psychosocial needs. Capacity of parents and care givers will be built through adapting existing training modules to be more child-focused and HIV-sensitive, printing educational materials, conducting training and connecting cargivers with CSOs. Counseling and home visits will be provided through community-based organizations, with referrals made as needed and will include parent-child activities to develop communication skills. Family camps for children aged 5-12 and their families will be hosted periodically to address issues of stigma and discrimination, strengthen family bonds, provide information and develop negotiation skills around sexual choices and reproductive health. (PR-ACCESS; SRs- PLAN, WVFT, AIDSNet, LSDF, TNAF, PPAT)

2.2.2: Provide psychosocial support to and build self-esteem in HIV-infected/affected children and youth. Psychosocial support will be provided HIV-infected children and youth to address psychosocial difficulties as well as to build self-esteem. Camps will be hosted periodically to address issues of stigma and discrimination, support ART adherence, and address positive prevention strategies. Self-esteem will be fostered through participatory activities. Peer group activities will be supported to foster feelings of social inclusion, including sharing of experiences common to a particular age group. (PR-ACCESS; SRs-PLAN, WVFT, AIDSNet, LSDF, TNAF, PPAT)

SDA 2.3 – Social support: Service delivery

2.3.1: Increase household economic capacity for CABA and other vulnerable children. Mechanisms will be put into place to more effectively and efficiently target vulnerable households in need of economic support to ensure that CABA and other vulnerable children are able to meet their basic needs. Staff from national and local government working with local community actors will put in place transparent systems to identify families in need without duplication or omission. Economic capacity will be increased through identifying and referring eligible family members to job placement centers or for vocational skills training, or provision of small grants for income generation. This will be coordinated through the provincial SDHS. Activities of the Positive Partnership Program which pairs families with PLHIV members

with other families not affected by HIV and provides them with microcredit will be expanded to all provinces targeted by this proposal. This partnership provides both families with economic benefits and improves acceptance of PLHIV in the community. Funds from GFATM will be used to provide economic support to children and families from ethnic minorities affected by HIV who are not currently eligible for assistance from SDHS. Funds are requested for the first three years of the grant. The Thai government will absorb this cost from year three of the program. (PR-DDC; SR-MSDHS, PR-ACCESS; SRs-PLAN, WVFT, AIDSNet, LSDF, TNAF, PPAT)

2.3.2: Reintegration of children in residential care to live in a family environment through promotion of kinship and foster care. Many children residing in institutional care settings are CABA. Relatives of children currently in institutional care will be traced and supported in the process of reintegration of these children back into a family environment. Proposed guardians will receive training on standards of kinship and family care, child's rights and protection. Caregivers and children placed under foster care will be supported and monitored through home visits and counseling. Selected CAGS will be sensitized to issues of children in institutional care through informational briefings and visits to institutions where children reside. (PR-DDC; SR-MSDHS)

2.3.3: Protect the most vulnerable through legal services, rights protection, and management of child abuse. Information will be provided to CAG members to facilitate understanding of Thailand's rights protection laws and procedures in case of child abuse or neglect and how the case can be handled and appropriately referred. TAOs and PLHIV groups will be supported to provide education to targeted community groups and stakeholders. (PR-DDC; SR-MSDHS)

<u>Objective 3:</u> Increased social acceptance and inclusion for adults and children infected and affected by HIV, as well as for those marginalized due to other causes.

SDA 3.1 – PLHIV leadership in stigma reduction

3.1.1: Build capacity of the Thai Network of People with HIV (TNP+) to develop key messages around HIV stigma. Communication materials for use in IEC/BCC training workshops will be developed by TNP+ members. A training workshop will be held to orient TNP+ members and YLHIV on the principles of stigma reduction communication material development. Materials and tools produced will be used by CAGs and TNP+ networks countrywide. (PR-ACCESS; SR-TNP+)

3.1.2 Share experiences of living positively among PLHIV and YLHIV through various forms of storytelling. Professional writers will be engaged to provide coaching to young PLHIVs to share their experience of living positively through various forms of storytelling. End products in the forms of life stories, novels, or short stories will be published and disseminated widely to schools, CAGs and NGOs networks. (PR-ACCESS; SR-TNP+)

3.1.3 Mobilize community radio to promote child rights, child adoption and increased understanding of HIV and AIDS. Workshops will be organized for community radio personnel to sensitize and raise their understanding on HIV and child rights issues. Civil society groups in each region will develop a plan to work with local community radio stations to feature stories and experiences related to HIV, child rights, and social protection to be aired by the radio stations. (PR-ACCESS; SR-TNP+)

3.1.4 Hosting of a short film contest among PLHIV and YLHIV. Training will be organized for groups of PLHIV and YLHIV to develop scripts and produce short films. End products will be disseminated among CAGS, local schools and to the public. (PR-ACCESS; SR-TNP+)

SDA 3.2 – Promoting stigma reduction by mass media

3.2.1 Encourage media sensitization. Strategic partnerships with mass media at national and local levels will be fostered. Professional media organizations will be supported in developing a code of conduct governing the reporting of children's stories in terms of confidentiality, sensitivity, and respect of children's rights. Existing international guidelines for media reporting on children will be adapted and used to train journalists, editors, photographers and program-makers about children's rights, including on how to appropriately report on marginalized and vulnerable children, including those affected by HIV

in an accurate and substantiated way and challenge those who discriminate. (PR-ACCESS; SR-TNP+)

3.2.2 Feature stories of children affected by HIV and AIDS on Thai public television. The Thai Public Broadcasting Service (TPBS), has expressed willingness to feature a public interest film produced by TNP+ that captures the lives of PLHIV and YLHIV at no charge. (PR-ACCESS; SR-TNP+)

Objective 4: Strengthened national, provincial, district and sub-district (including community) strategic information systems for improvement of services to vulnerable children

SDA 4.1 – HSS: Information system

4.1.1: Strengthened, unified M&E system focused on CABA. A coordinated project information system for CABA, linking government and community data sets, and building on the existing national M&E system with additional, needed components specifically for CABA will be developed enhancing the overall health and social protection monitoring of children for Thailand. Tools will be consolidated and guidelines developed to support this. PRs, SRs and the SSRs will be oriented on the M&E guidelines, indicators, data collection tools, and reporting systems. Data quality assurance monitoring will be performed and technical assistance provided as needed. (PR-DDC; SR-Pact)

4.1.2: Increased relevance of quality data for programming and policy. As program implementation begins, data will be generated on numbers of children to be reached in each target province and participating TAO. Programming information on their needs, including situation analysis of families and caregivers, mapping of existing services, setting of coverage targets, as well as program planning, coordination and monitoring, including reporting of the service delivery results will be operationalized around the TAO and CAGs. Sub-provincial M&E units will be established to support the community and facility level programs. To ensure that evaluation results feed back into programming and effective use is made of the information generated, periodic submissions will be analyzed, documented, and prepared for provincial and local stakeholders.

Data will be generated to review the coverage, accessibility, efficiency and quality of the services at the community level, including data related to capacity development and systems strengthening. Program effectiveness will be linked to outcomes by comparing the well-being of CABA in different types of care settings for the first time. Studies will be conducted to determine the up-to-date CABA and vulnerable children estimates and needs by region and province, which will help drive resource mobilization efforts. Data will also be gathered on populations of children not in households (street children, child laborers, migrant children, orphanages) to monitor the shift of children between types of care or outside of care giving systems. (PR-DDC, SR-Pact)

SDA 4.2 – M&E capacity development and data use

4.2.1: Increased M&E capacity at all levels. M&E capacity will be strengthened for PRs, SRs, and key M&E stakeholders, including upgraded skills and systems so that the overall health and social protection monitoring of CABA is enhanced. Through the development of coordinated national, provincial, sub-district and community M&E plans, mechanisms will be developed to accurately measure the outputs and short term outcomes of interventions, providing a basis for periodic review of interventions to make them more effective. Training and technical assistance for M&E plans including follow-up will ensure systems improvement at multiple levels.

These mechanisms will include participatory appraisal methods for which M&E capacity development will be carried out at the sub-district and community level (Children Action Group). In addition, small grants will be provided to set up local M&E units. Community members at CAGs will own and use data to measure outcomes of HIV/AIDS services and social protection interventions that they are working on. Service quality of the community responses will be established at baseline, standards will be developed for the service package, and quality improved during the life of the project through data use around local initiatives. (PR-DDC, SR-Pact)

4.2.2: Increased data use to improve programming and policy at national and provincial levels. Existing gaps in generating useful information at the provincial level will be addressed through standardization

of tools and training of key individuals and data users. In coordination with the National M&E steering committee and NAMC, at the national and the regional levels, meetings will be convened with the HIV and AIDS M&E units and the provincial PCMs and Child Protection Committees (CPC) and sub-provincial M&E units (TAO, for example). Enhanced coordination with RCC trial sites will result in better sharing of information and linkages between CPC and the Provincial AIDS Committee. (PR-DDC, SR-Pact)

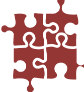
4.2.3 Increased data use at the sub-provincial level to improve programming and advocacy. Through capacity development interventions, at the sub-provincial (TAO) and local levels, communities will be helped to understand CABA M&E, factors that determine vulnerability in that community, what community members could do in terms of programming or advocacy for an effective response, and how to both feed back the data into the reporting system as well as measure the results of their efforts. Local M&E data use will be supported by the issuance of small grants so that community-based service coordination points, such as the CAGs, will benefit from M&E strengthening through fledgling M&E providers. Activities will be carried out for establishing a minimum standard for all the involved stakeholders. Pilots for CAGs with M&E small grants will be evaluated and, if appropriate, scaled up in the second phase. (PR-DDC, SR-Pact)

SDA 4.3 – Operational research, evaluation and selected studies

4.3.1: Relevant OR and evaluations inform programming. Focused research and evaluation is fully in line with the strategic priority of the National HIV/AIDS strategy and plan of Thailand, and the OR initiative is linked to an established set of national research and evaluation priorities established in 2010, as well as specific needs of child-focused programming for CABA. In addition to the project baseline, mid-term and the end line studies, research among program implementers will be supported. These studies will most likely test the feasibility for establishing and strengthening referral systems which link community-based programs at the sub-provincial level and below with respective technical services from health and other facilities, including schools and social protection agencies. Operations research may also help determine approaches to set standards and improve the quality of care, for example, of pediatric HIV care for underserved populations of children, or other relevant packages that meet the needs of the largest number of beneficiaries including caregivers.

Important initiatives in testing a new set of pilot indicators measuring the outcomes of improved well-being or quality of life of CABA will be developed to gauge project effectiveness in the overall improvement of the physical, mental and social well-being of beneficiaries and the quality of the vital connection between care-givers and children.

A study on the unit cost for interventions for CABA will also be included. It is anticipated that the unit cost or cost effectiveness study will provide essential planning data, and help determine the best strategy for caring for CABA and ensure value for money for potential donors. (PR-DDC, SR-Pact)



Complete this version of section 4.4.1(a) (b) and (c) if the applicant selected option 1 in section 3.1 of the Proposal Form

Option 1 = Transition to a single stream of funding by submitting a consolidated disease proposal

4.4.1 Interventions

→ This section should be completed in parallel with the Consolidated Performance Framework and detailed budget and work plan

(a) Overview of programmatic activities

Describe the objectives, service delivery areas (SDA), and activities of the consolidated disease application. **The description must be organized in that exact order and the numbering system must match the Consolidated Performance Framework, detailed budget and work plan.**

The narrative description of the Round 10 interventions should reflect all objectives, service delivery

areas (SDAs), and activities in the Round 10 consolidated disease proposal, but distinguish between what programming is being continued from existing grants versus new programming for Round 10.

The description must identify:
(1) who will implement each area of activity (e.g. Principal Recipient, Sub-recipient or other implementer);
(2) the targeted population(s);
(3) what changes in implementation and/or the targeted population(s) have occurred, if any, for those elements which are from existing grants and continuing in this consolidated disease proposal;
(4) any links between the existing grant activities to be continued in the consolidated disease proposal, as these activities previously existed in separate grants;
(5) any links between the proposed activities and existing Global Fund grants for other diseases or HSS; and
(6) how duplication will be avoided if there are linkages identified in points (4) and (5) above.

(b) Changes to existing SDAs, programmatic activities, indicators and targets

In the table below, list the SDAs and activities of existing grants consolidated within the Round 10 consolidated disease proposal. Explain whether each SDA and activity from an existing grant will be included in the Round 10 consolidated disease proposal by indicating an increase in scale, decrease in scale, continuation without change, or discontinuation. Provide justification for any proposed changes or discontinuation.

→ *The proposed changes should be clearly and systematically reflected in the Consolidated Performance Framework*

Round #	Service Delivery Area (SDA)	Activity	Proposed change	Justification for change
→ *use "Tab" key to add extra rows*				

(c) Changes to existing impact or outcome indicators and targets

Describe any major changes in indicators and targets that may have occurred due to the programming described above in sections (a) and (b) and that is supported by the Consolidated Performance Framework. In particular, if there has been discontinuation or change in indicators or if targets have been changed between previous grants and the Round 10 proposal, describe why this has occurred.

4.4.2 Addressing weaknesses from a previous category 3 proposal

If relevant describe how the weaknesses identified in the TRP Review Form of a previous category 3 proposal have been addressed.

The weaknesses of the previous proposal identified in the TRP Review and how they are addressed in this Round 10 Proposal:

Major weakness

1. The objectives and activities are too broad and do not specifically focus on orphans and vulnerable children. No clear linkages were demonstrated between the goal, objectives and activities. The budget indicates the observation with only 13% going directly to orphans and vulnerable children.

- This Round 10 Proposal has a hard focus on "children affected by HIV and AIDS as well as other vulnerable and marginalized children living within communities of high HIV prevalence."
- There is a clear progression of activities leading to the achievement of objectives and the objectives leading to attaining the goal. Please note Section 3.4 Proposal Summary.
- The budget in this proposal will leverage and build on other resources. Please note Section 5.3 Budget Summary.

2. The proposal does not adequately identify and address over lap between the target population, activities and geographical coverage with previous and current grants. Some activities, such as PMTCT, are also covered by previous grants, such as the Rolling Continuation Channel Wave 1 grant.

- Linkages with previous grants and other fund sources are shown in Sections 4.4.7 and 4.4.8 for the provinces selected as the target area for the proposal.

3. The proposal does not demonstrate sustainability and potential for impact; neither does it adequately demonstrate capacity of the PR and OR to implement this kind of program. No impact level indicators have been provided in the performance framework. No reference is made to the contributions made by other actors addressing this target group.

- Please review Section 4.5 Sustainability.
- Intended impacts of the interventions will be clearly articulated in the design and measured periodically throughout the life of the Project.
- The following impact indicators are included in the performance framework:
    - % of children aged less than 15 years old with advanced HIV infection receiving ART
    - % of orphaned and vulnerable children aged 0-17 whose households received at least one free basic external support in caring for OVC
- A capacity assessment report of the PRs and SRs is included in Section 4.7.1.
- An assessment of the resources for children available in the targeted provinces and their sources is included in Section 4.4.8.

5. The program, unlike its title and main objective suggest, seems to particularly focus on the HIV-AIDS-related needs.

- The focus of the Round 10 proposal is stated in the goal statement and activities consistently address the stated target populations.

6. No distinction between orphans and vulnerable children is made on the cause of becoming an orphan. However, no convincing strategies have been provided to address stigma and discrimination that still may prevail.

- Several of the proposed interventions seek to promote social inclusion and diminish stigma and discrimination.

- Orphans are included without regard for the reason they have been orphaned.

7. There is no mention of a policy on condom distribution to children under 18 years of age and gender issues are not properly addressed re. HIV/AIDS prevention.

- There is no specific policy on condoms for adolescents.
- However, access to condoms usually is not an impediment to usage for adolescents as the commercial sector makes them available in literally thousands of stores and kiosks.
- Increasing condom use among sexually active adolescents is encouraged by the Project.
- Section 4.4.5 addresses gender issues. It is recognized that gender-responsive interventions are critical to the success of this project.

Minor weakness

1. There are different unit costs for the same tests.

- As noted, internal consistency will be assured.

2. The use of the 2007 AEM when 2008 data are available.

- The most current data are being used in this proposal.

3. The financial gap analysis excluded Round 8 funding.

- All funds for HIV program in Thailand are included for the financial gap analysis in the proposal.

4.4.3 Lessons learned from implementation experience

How do the implementation plans and activities described in 4.4.1 above draw on lessons learned from program implementation (from either Global Fund financed or non-Global Fund financed programs)?

Domain	Lessons Learned	Actions Taken in R 10
Continuum of Care	In R1 RCC PLHIV participated effectively in developing treatment plans in partnership with hospitals.	PLHIV will take an active role in facilitating the community continuum of care and strengthening the case management system
Human Resources	The Novices AIDS Intervention and Rehabilitation Network (NAIRN), Chiang Mai, experienced success in engaging novices and other monks as peer educators. They also were valuable resources in providing outreach services to orphans, ethnic minority children and the children of migrants	Novices and other monks will be participating in the CAG in all 1860 Tambons reached by the Round 10 program. The resources of the religious communities will be tapped and they will participate actively in the Round 10 activities.
Program Models	The Art Therapy Project of the AIDS Access Foundation reduced some of the psychological problems of HIV+ children, enhanced their self-esteem and established support networks with other community-based agencies	HIV+ youth volunteers will participate actively in peer support and media campaigns in Round 10 program. Creative program models will be developed to meet the specific needs of the HIV + children
Male	Through the “Family Love Bonding Hospital”	Staff of district hospitals

	involvement in MCH	Project of the DOH, experience has shown that husbands can be engaged in MCH services, including PMTCT and care for children. Number of children born to HIV infected mothers lost to follow up has been reduced in participating hospitals.	throughout the targeted provinces will receive training in couples counseling and motivating male involvement in ANC and in caring for their children.	
	Stigma Reduction	Experience of the R2 ECAT Program demonstrated effective use of mass media, including community radio, to reduce stigma related to HIV.	The Round 10 activities will include engaging media, including community radio, to educate the community about HIV and AIDS.	
	Resource mobilization	The Positive Partnership Project of the Population and Community Development Association has demonstrated how small business ventures can be established and thrive	Income generation initiatives will be promoted to assist the families of HIV+, vulnerable and marginalized children in the target province	
	Information systems	UNICEF and MSDHS support TAOs in developing community data bases relating to children and train them in the use of the data.	Every sub-district in the Round 10 activities will engage in collecting and utilizing data relating child welfare	

4.4.4 Enhancing TB/HIV collaborative activities

Describe:

(a) how the proposal will contribute to strengthening TB/HIV collaborative activities; and
(b) the collaboration between the National TB program and the HIV services of your country.

(a) how the proposal will contribute to strengthening TB/HIV collaborative activities

In order to achieve successful treatment outcomes and prevent resistance, strict adherence to treatment regimen is important. Since this HIV proposal will establish a case management system at the district hospital level closely linked with community mechanisms to provide a continuity of HIV-related care for children and their families, the working system will enable providers to track down those TB-infected cases who have been lost to follow up in their communities or those cases with potential for poor adherence to anti-TB treatment. When identified, providers can mount a corresponding action plan to overcome obstacles in returning for a visit or improving adherence to treatment of TB. Currently, strategies to ensure adherence to anti-TB treatment at the district hospital are the directly-observed therapy (DOT) without appropriate psychosocial adherence support for TB-infected children who are facing the burden of being required to take many pills at prescribed times. This HIV proposal will therefore develop strategies/tools and roll out age-specific adherence counseling service for both HIV and TB treatment at the same time.

One of important measures to control TB infection in the community is to identify those who are exposed to active TB cases and take appropriate steps to prevent from developing the full blown disease. Given the family and community approach to case management established at district hospitals, identification of children who are exposed to patients with active TB cases in their families, orphanages, or communities will be achieved. Subsequently, diagnosis and treatment of either latent or active TB will be provided.

Lastly, the coverage of TB case finding in ARV clinic and coverage of VCT in TB clinic will be one of the important indicator case management has to monitor. Through this mechanism, the good coverage of those services can then be sustained.

(b) collaboration between national TB and HIV program

Tuberculosis is the most common opportunistic infection in Thai PLHIVs. In 2008, about 20% of PLHIVs were fund to have TB infection. Thailand had therefore established a coordinating mechanism between TB and HIV programs as well as the surveillance of HIV infection among TB patients and providing capacity building to those who care for TB/HIV-infected patients. The country also has established intensified TB case findings at various health settings by the screening and diagnosis of latent and active TB infection in HIV-infected patients every 6 months. The screening and diagnosis of TB includes history taking, laboratory tests, and a chest X-ray. In addition, TB control at the health care facility is included.
In relation to national program achievement indicated by data from 2008-2009, 93% of HIV-infected patients received TB screening and 87.6% of TB patients received VCT

4.4.5 Enhancing social and gender equality

Using specific references to objectives, SDAs, and activities included in section 4.4.1, explain how the Round 10 interventions address issues related to social and gender equality and confirm that these items have been properly costed in the budget.

This project will connect the public health system with community-based care and social protection in order to develop services and support which are needed for the optimal development of all children and their families in the targeted provinces, irrespective of their culture, race, traditions, ages or gender. But the focus of the interventions will be the HIV+ children and their families, and children in similar circumstances who must cope with many challenges in the community. To reach these children, the public health services for their parents must be strong, beginning with the ANC clinics where many of the mothers learn for the first time that they are HIV+. It is critical for providers to be able to facilitate coping of these parents, both of them, throughout the period of pregnancy, during delivery, and post natal care. Fathers will be encouraged to be full participants and to learn their HIV status as well. And these services need to continue for the children as infants, and young children, up through the teenage year until young adulthood.

To engage the fathers as well as the mothers, personnel in health and social services, in the schools and in other aspects of community life must be sensitized to understand the complexity of HIV, and respect individual sexuality choices and lifestyles. Equal access to health and social services are very much hindered by the social attitudes about gender roles which get expressed in attitudes about parenting, in decision making and expectations of the HIV+ mother, and in decisions about having additional children. Children of pre-school age are often restrained from normal childhood activities as they are perceived as “sick”, and feared by some as a possible source of infection. During the adolescent period these infected or affected teens often face their sexual maturing with high anxiety as they struggle with their identity and what it means to be positive.

Special attention will be given to ethnic minority groups in the six northern provinces in Thailand, as these stateless people are facing difficult circumstances as they are they are not eligible for services provided to Thai citizens. The Government recently agreed to provide them with Thai citizenship if they pass the validation process starting this year. Among these ethnic minorities, most of them from the six northern provinces, 130,000 are registered to be in the validation process. The NHSO has already included them in the ARV schemes, beginning with the current budget, and the Ministry of Education has agreed to include them in the education budget allocation. However, the MHSD still have no plans to extend their cash assistance for people living with HIV to them.

Objective # 1 SDA 1.1.2 will provide age and gender specific counseling package to adolescent girls and boys. SDA 1.1.3,1.2.1, and 1.3.3 deal with capacity development for the workforce and will seek to improve providers’ attitudes related to social and gender equality as per the above issues. To deal with this effectively, service providers in health, social protection, teachers, and care providers in orphanages and day care centers will have many opportunities to not only learn new skills but to adopt values and attitudes which support equality and gender sensitivity. SDA 3.1.1, 3.1.2 provide exposure to many types of training experiences, interacting with infected/ affected youth and women through Y-PLHIV and W-PHLA groups, and through advocacy efforts by PLHIV-TNP+ in order to develop a better understanding of these issues from an “insider” point of view. Furthermore, SDA 1.1.2 will incorporate inputs from children, youth and PHAs to capture their perspectives in developing messages for training and capacity building and prototypes of communication materials for institutional distribution

Objective #2 SDA 2.1.1 will build on a pilot effort of collaboration between UNFPA and DOH which engages men in a meaningful way in ANC and PMCTC services. This helps reduce loss to follow-up of positive mothers, and improves tracking of children infected and affected by HIV. The project under SR-DOH is planning to scale up this effort in a larger number of hospitals and intensify the efforts at the community level to promote male involvement in the whole spectrum of family planning, ANC, post partum, and child care services. At the service points, both activities and environment will be adjusted to accommodate men who came with their partners to enable them to participate in improving maternal and child health, including care for the children. SDA 2.2.1 includes community efforts in

addressing men to encourage male involvement in parenting. SDA 2.1.4 and 2.2.3 support the development of psycho-social and sexuality education support activities for children at different ages. Materials that are developed and distributed will take into account gender issues facing the target audiences. For teenagers, activities will take into consideration gender sensitivities e.g. sexuality education will be shaped by the interests of boys and girls or transgender's who are participating. SDA 2.3.1 will focus on the underserved populations such as ethnic minorities. The Project will provide cash assistance to them for three years along with the same health and psychosocial services to assist PLHIV and their children as the Thai citizens are receiving, then the MHSD will continue this cash assistance.

Objective #3 SDA 3.1.1, 3.1.2 will provide opportunities for children and PLHIV to communicate to the community their commitment to be productive members of society. Women and children will be encouraged to be speakers/ presenters of these messages to eliminate the myth that HIV/AIDS is associated more with men, and women, especially young women, are not at the same level of risk. The campaign aims to reinforce the message of early detection especially among couples, and that if they learn that they are HIV positive women have their fertility rights like other women, and HIV+ children should enjoy their normal childhood like others. In addition, the public will become more aware and be more proactive in protecting child rights and not discriminating against people living with HIV.

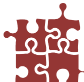
Objective # 4 SDA 4.1.1 promotes building strategic information systems at national, provincial, and Tambon levels. Service records at health, education, social services, and community activities will be aggregated by gender. Gender inequality in those services will be monitored and data will be fed back to implementing partners to adjust their targeting strategy to keep a better balance throughout the project. SDA 4.1.2 will try to shift the balance among children in rural and urban areas receiving services to improve social equity, as MICS indicates a strong imbalance.

4.4.6 Partnerships with the private sector

Describe how contributions related to: (i) co-investment from the private sector, and (ii) donated goods or services, will add value to the planned outcomes of the proposal. Make specific reference to the associated objectives, SDAs, or activities to which they are linked.

The 2 PRs will work together through the Joint Strategic Planning Committee of the Round 10 proposal to obtain co-investments from the following agencies who have indicate their willingness to support Global Fund Round 10:

- The Advocacy Campaign under the TNP+ to reduce stigma (Objective 3, SDA 3.2, Activity 3.1.1).
- Thai Public Broadcasting Services (TPBS) TV will contribute broadcasting time for the documentary series developed by the TNP+ (Objective 3, SDA 3.2, Activity);
  - The series will be also shown on local Cable TV in at least ten provinces at no charge.
  - In addition, over 50 community radio stations will use script of the series developed by TNP+ in their broadcasting at no charge.
  - With this contribution, the series will reach no less than 200,000 people.
- PATH and Chevron-Thailand will contribute to parenting education and youth peer-to peer activities in at least four southern provinces (Objective 2, SDA 2.2, and Activity 2.2.1).
- Rotary-Thailand will replicate education materials for vulnerable children(Objective 2, SDA 2.2, Activity 2.3.1)
- Contributions in funds and in kind will be leveraged from foundations and private companies already funding child welfare initiatives the intervention areas. (Objective 2, SDA 2.3, Activity 2.3.1)



Only complete section 4.4.7 if the applicant selected Option 2 or 3 in section 3.1 of the Proposal Form, DO NOT COMPLETE section 4.4.7 if the applicant selected Option 1 in section 3.1 of the Proposal Form

Option 1 = Transition to a single stream of funding by submitting a consolidated disease proposal
Option 2 = Transition to a single stream of funding during grant negotiation
Option 3 = No transition to a single stream of funding in Round 10

4.4.7 Links to other Global Fund resources

Describe in the table below the linkages between this Round 10 proposal and existing Global Fund resources. It is important to list the SDAs and activities as outlined in the current proposal in the left hand column, add a description as to how they relate to previous grants in the middle two columns, and then outline how the Round 10 proposal specifically addresses this in the right-hand column.

Key SDA and activity as proposed in the Round 10 proposal	Existing grants		Round 10 Proposal
	Round 1-RCC Grant	*Round 8 Grant*	
SDA 1.1 Health system strengthening			
1.1.1 Ensure continuity of HIV-related care for children affected by HIV/AIDS and their families across the health facility-community continuum	Youth and PHA friendly services	Increase access of Friendly services to MARPS	This SDA will align services for young PHAs to YPSF, through referral linkages, and case conferences.
1.1.2 Integrate psychosocial support into health care services and support programs	Training of counselors in YPSF	Training of counselors for providing sexual health counseling to MARPs	This SDA will carefully target health and NGO workers either to avoid redundancies or to build upon former knowledge and skills of health care workers who have been trained.
SDA 1.2 Community System Strengthening			
1.2.1 Build skills for service delivery, advocacy and leadership among community-based organizations	PR/DDC engage TA organizations to build capacity of PCMs which included NGOs/CBOs in advocacy for HIV integration in local development plans	PRs/SRs enhance capacity of MARP advocate groups to represent their voices in the PCMs.	This SDA will utilize PCMs to mobilize Provincial Child Protection Committees to promote and act on CABA agenda and children's rights protection. GF-10 will avoid selecting Tambons that GFRCC and Round 8 are targeting. However, in the GF-10, targeted areas where CAG will be formed, lessons learns will be gathered through exchanges with Tambons who already have integrated HIV into their planning
1.2.2 Strengthen coordination, linkages, and referral systems	TNAF building capacity for 60 TAOs to integrate HIV in their development plan	**n/a**	CAGs will serve as a key mechanisms to bring together actors at the

between CBOS and CAG with other stakeholders and service providers			community level that have had capacity development training from RCC and Round 8, as well as other non-global fund resources.
SDA 2.1. Health System: Service Delivery			
2.1.2 Improve virological testing uptake for HIV exposed infants	Round 1-RCC promotes VCCT through YPSF under the prevention component. Under the care and support component, PLHIV are accessing ARV/OI treatment.	n/a	This SDA will focus its efforts on women who tested positive at ANC clinics and with couple counseling enhanced, PLHIV parents will be enable to get their children to receive timely and proper care services. Young PLHIV will receive enhanced psychosocial support.
SDA 2.2 – Community systems: Service delivery			
2.2.1 Build capacity of caretakers to provide holistic care for HIV-infected/affected children and adolescents	Capacity building for PLHIV groups (member of the TNP+ or CCC) and people living with HIV/AIDS through ACCESS/ TNP+ and NCA (Faith base group)	n/a	SR/SSRs will complement Round 1-RCC with intensified efforts on psychosocial care both at services and community levels.
2.2.2 Sexuality/HIV education	Sexuality/HIV education for youth in school and community.	Sexuality education for MARPS	Children ,YPLHIV will be receiving counseling support tailored to their situation. Parenting education in community will be intensified. M Ed will enhance their Student Protection and Support System to incorporate CABA agenda and child development issues.
SDA 3.1 Participation of PLHIV, (TNP+) to reduce stigma in all settings			
Skills building activities to build its own capacity to reduce stigma associated with HIV in children	TNP+ has been part of the stigma reduction campaign working group under ACCESS. Key messages encourage people to take VCCT for early detection, and that HIV/AIDS can be treated.	n/a	This SDA TNP+ will lead the formation of the campaign—and build upon lessons learned in media strategy and seek to complement the Round 1-RCC efforts .
SDA3.2 Promoting stigma reduction by mass media			
Promoting stigma reduction by mass media	National Campaign on prevention of HIV, condom use, early detection by VCCT, and promoting	National campaign to promote human rights and gender equality	The campaign in GF 10, led by TNP+, and focus on promoting positive role of people living with HIV to

	youth friendly services		beware of their productive contribution to promoting social understanding of HIV, supporting of CABA and integration of orphans into community
SDA 4.1 - HSS: Information system.			
A strengthened, unified M&E system focused on CABA and other vulnerable children will be developed which will contribute toward improved programming and policy development.	Round 1-RCC will develop the unified National M&E Plan with R8 and R10 PCM is to be equipped with provincial youth database for strategic planning	Round 1-RCC will develop the unified National M&E Plan with R8 and R10 PCM is to be equipped with provincial MARPs database for strategic planning	This SDA will consolidate M&E with system started by NAMAC in Round 8, by having data related to MARPS and CABA collected, compile in an accessible format at provincial and Tambon level. Data collected under Round1-RCC on CABA will also be combined in the same platform.
SDA 4.2: M&E capacity development and data use.			
M&E capacity, including data generation, analysis, and use will be strengthened at all levels.	Focusing in capacity building for PCM to collect and utilize strategic information to guide interventions. Using M&E data to advocate for sexuality education policy	Capacity building for PCM to collect and utilize MARPs data at provincial and Tambon levels	Focusing on capacity and system building for data collection for CABA and vulnerable children for Provincial Child Protection Committee. At Tambon level, GF10 will develop capacity of CAG/TAO in data for gap analysis and strategic planning.

4.4.8 Links to non-Global Fund resources

Describe whether the Round 10 interventions (e.g. goals, objectives, SDAs, and activities) listed in section 4.4.1 have linkages to programs financed through non-Global Fund resources. If such linkages exist, list the non-Global Fund financed programs and their activities, and explain how the proposal complements those programs and activities. In addition, explain how the Round 10 interventions do not duplicate existing programs and activities supported by non-Global Fund resources.

Health related interventions

The National Health Security Office (NHSO) provides support for virological testing of infants and ART for children and adults. Funds from Round 10 will enable increased access to testing and treatment for infected children through improved follow-up of HIV-exposed infants by introduction of a case management system spanning clinics and communities. NHSO has also supported delivery of psychosocial services to young people with HIV. US CDC has complemented this through development of a pediatric HIV disclosure module. Funds from Round 10 will be used to expand these interventions to all target provinces through development of materials and involvement of additional young people in delivery of psychosocial support.

In the area of male involvement, UNFPA has supported MOPH to develop a model on male involvement in MCH, and the US CDC has supported development of curricula for couples counseling. Funds from Round 10 will be used to scale up this approach to targeted provinces.

Community based interventions

NHSO currently supports PLHIV groups in providing care to other young people with HIV, particularly with adherence at community level. Funding from Round 10 will also allow PLHIV groups to be more active in the Child Action Groups and better link care for CABA from hospital to community and vice-versa.

Social protection interventions

MSDHS current provides living allowances (approximately US$34/month) to foster parents caring for children with HIV. Funds from Round 10 will be used to enhance the quality of kinship and foster care by providing additional training and support and developing a set of national standards, and will also expand kinship and foster care by using communities to advocate for and adopt kinship care as opposed to relying on institutional care. Many foster families currently do not access these funds, however, as they fear stigma and discrimination. By broadening eligibility for these funds as proposed in this proposal to families not directly HV impacted, fear of stigma should be reduced benefitting CABA and other vulnerable children.

Monitoring and evaluation

MSDHS currently provides support to Family Development Centers (FDCs) to develop a database to monitor abuse and implementation of child protection. Funds from Round 10 will support development of Child Action Groups (CAGs) that will be trained in community mapping to use these data to advocate for more supportive policies and better program for CABA and other vulnerable children.

4.4.9 Strategy to mitigate unintended consequences of additional program support on health systems

Describe:

(a) the potential risks and unintended consequences on health systems that may result from the implementation of the proposal; and
(b) the proposed strategy for mitigating these potentially disruptive consequences.

1. Advocacy efforts to increase demand and access to health and psychosocial services at the community level may succeed too well and the demand may exceed the local capacity to deliver the increased volume of service.
   A. Capacity building at the local level will include both increasing skills of the current staff and increasing the staffing levels if that is required to meet the demand. The changes in the demand curve will be monitored. In addition, local resources will be mobilized in order to respond to local needs.

2. The current capacity to provide services at the local level may not be there, especially counseling skills. If the demand for services can not be met it could diminish the motivation of the local people to seek services when they are needed.
   A. Local capacity to deliver the expanded range of services will be assessed through the SRs and SSRs responsible for program implementation in the area

3. The case management system will seek to track and reach patients who currently "falling between the cracks" as they move from one component of the health services delivery system to another. Some of the existing health staff may not embrace this initiative with enthusiasm because it requires additional effort and staff may already be working at their full capacity.
   A. To the extent possible, existing health care staff should participate in redesigning this aspect of the health services delivery system. They should be assisted in understanding the nature of the problem, the constraints and the options.

4. Reintegration of children to their extended families and communities will not always be supported with enthusiasm by staff of the private institutions, as it may be seen as a threat to their jobs.
   A. Staff of the institutions should participate fully in the relocation of children. Incentives should be provided, as possible, to minimize the threat to jobs in the institutions. (The propensity of institutions to do what is necessary to survive is a core liability.)

5. Linkages with other programs sponsored by various ministries and NGOs, which are essential to deliver the client-centered services, may not be possible or may be resisted by the established facilities.

   A. Coordination meetings with other service providers will be part of the introduction of the Project and will be held periodically as needed. Strong leadership from the TAO will be needed.

4.5 Program Sustainability

4.5.1 Strengthening capacity and processes in HIV service delivery to achieve improved health and social outcomes

Describe how the proposal contributes to overall strengthening and/or further development of public, private and community institutions and systems to ensure improved HIV service delivery and outcomes.

➔ *If available, refer to country evaluation reviews*

➔ *Support explanation with excerpts from documents that the country has adopted, identifying the source, such as a National Disease Strategy*

The National AIDS Program in Thailand has been recognized as a leader in AIDS response in terms of its ability to implement programs in coordination with partners at all levels, particularly in scaling up services to prevent the transmission of HIV from mothers to their children. The national HIV/AIDS strategy and plans are prioritized, evidence-based and costed. There are defined roles and responsibilities for all stakeholders. There is also an overall national monitoring and evaluation plan. The government has decentralized power and authority to local authorities in implementing public health programs. Although the provincial local administration, municipality, sub-district local administration all receive budgets and implement activities for disease prevention and health promotion, their capacity to conduct and monitor programs focusing on children's services is very weak. The efforts by the government and donors, including R1-RCC, such as implementation of ECAT to develop community mechanisms to help mothers living with HIV and AIDS and their children, as well as efforts to develop coordinating mechanisms that link HIV and AIDS work at the Tambon and provincial levels in 43 provinces are underway and will soon start showing results. As much as the results depend on the engagement and potential of respective community, the capacity strengthening that will happen as a result of the interventions outlined in this proposal will further enhance the delivery of HIV services to children and help create sustainable architecture for the same. There will also be increased potential for the organizations involved to attract funding support both form the government as well as donors to scale up and enhance their quality programs.

The government and civil society coordinate at all levels for designing, delivering and monitoring services. The civil society sector in Thailand, including NGOs, PLHIV, faith-based organizations as well as key affected population groups, such as youth, MSM, FSW and IDU groups are quite active in the national response to HIV. Civil society, including the beneficiary groups have assumed leadership roles in the response to AIDS and are prominent stakeholders in the delivery of quality services. For example, under the R1-RCC, PLHIVs have participated in developing treatment and psychosocial services in partnership with the hospitals and the NSHO plans to expand the number of provinces using these services. However in the area of care for children affected by HIV, there are serious gaps and weaknesses. Therefore it is critical to help the government and involved organizations through this important sustainability building process. This proposal envisions technical assistance for building the capacity at all levels on data utilization and using information to develop measures to support children affected by HIV/AIDS and the vulnerable and marginalized children.

Although there is information available regarding children and AIDS at the central level, as has been highlighted in earlier sections of the proposal there is still a gap in this area at the provincial and tambon levels. There is also a gap in terms of integrating all the information to build a national system of M&E. This proposal will help instill the capacity at the community level to both generate and use relevant data. In addition to contributing towards an integrated national M&E system, through processes such as regular training and TA, the quality of the process as well as of the data generated will be ensured.

4.5.2 Alignment with broader developmental frameworks

Describe how the proposal's strategy aligns with broader developmental frameworks such as:

- Poverty Reduction Strategies;
- The Highly-Indebted Poor Country (HIPC) initiative;
- The Millennium Development Goals;
- An existing national health sector development plan; and
- Any other important initiatives.

The *National AIDS Plan* has been developed taking into account the directions provided by the '*Tenth National Economic and Social Development Plan for 2007-2011'*, 'the National Development Plan' (Annex), which is the most important plan for the overall country development. It states the vision for Thailand as a 'Green and Happiness Society' in which families are warm; community is strong; society is peaceful.

This proposal was developed based on the *National AIDS Plan* which is aligned with the development goals and objectives of the country and with the MDGs. The proposal objectives and strategies including strengthening health, community and social protection systems to increase access to essential services for CABA and vulnerable children in high HIV prevalence community in particular with the following objectives, targets and strategies of the 'National Development Plan' :

National Development Plan objective (1): to provide opportunities for learning by creating linkages between families, religious institutions, and educational institutions; to enhance health services, balancing among health care, promotion, prevention, treatment and capacity rehabilitation;

- This proposal will strengthen and coordinate policy and systems to integrate HIV-related health care community involvement and social protection for provision of comprehensive services to children and families across the health-community continuum. The psychosocial support will be integrated into health care services and support program.

National Development Plan objective (2): to increase the potential of communities by linking them in networks to serve as the foundation for developing the economy and quality of life;

- Under this proposal, Children Action Groups (CAG) comprising of community network with local administration, will be formed in the sub-districts and strengthened to better plan for and respond to children needs. CAGs will function as the community mechanism in identifying children in needs as well as using information to develop local plan for support targeted children towards quality of life.
- CAGs will also be trained on resource mobilization from both private sector and community to support children in needs as well as their families to generate incomes to be able to look after children in families.

National Development Plan objective (7): to promote good governance in government administration and the people's sector; to expand the role and capacity of local government bodies; to promote mechanisms and processes of participation in development; and to nurture a culture of democracy for peaceful coexistence.

- Local administration will be motivated and strengthened to play important roles in the CAG, as a community network to use local budget supporting identified needs and participatory plan developed by CAG.

Besides the *Tenth NESD Plan for 2007-2011* Thailand's endorsement of Universal Access and other international goal for HIV and AIDS, such as UNGASS, is reflected in the objectives of this proposal.

4.5.3 Improving value for money

Explain how the program that the proposal contributes to represents good value for money. Specifically, given the context of the epidemic in the country and the definition of value for money provided in the Guidelines, describe how the key interventions in the proposal represent the best balance of costs and effectiveness, with consideration to the desired achievement of both short and long term impacts.

1. The human resources perspective

The proposed set of activities include mobilizing local resources and people, including monks, volunteers and civil society organizations in a more coordinated response to HIV and AIDS. These local human resources are not only more attuned to the reality of people lives in their community, but are available at less cost than professionally trained persons who otherwise might be assigned similar roles.

2. The service delivery perspective

Proposed activities include strengthening a decentralized service delivery system which has some built-in efficiency by having services designed and delivered by persons with first-hand knowledge of what is needed and how those services are best delivered. One of the wasteful realities that will be addressed is the high percentage of children born to HIV+ mothers who are lost to follow-up. This will be dealt with through the functioning of a case manager system to help provide continuity of care as the individual patient or family moves through the health care system. Increased coordination also will be promoted among MCH services and HIV services, and men will increasingly be engaged in the health care of their families to increase incentives for completion of treatment regimens.

3. The therapy perspective

Adherence to treatment is a problem for children and adolescents dealing with HIV. For children it often is a lack of understanding of why the medicine is so important and for adolescents it is part of the identity crisis about being positive. Efficiencies, in this case, will be realized by reducing the waste of children and adolescents receiving expensive care over a period of years, and then scuttling those benefits by not adhering to the prescribed course of therapy.

4. The prevention perspective

Obviously there great efficiencies to be realized in preventing HIV infection. Not only is it very expensive to provide care and support, including life-long ART, to a single patient, but additional new infections from that individual to others also are avoided.

This proposal primarily focuses on strengthening care and support initiatives, but there is a continuum of prevention to care so that effective responses to the HIV+ also incorporate prevention components. For example, positive prevention includes receiving training on avoiding behaviors that put others at risk. And early detection of the HIV+ status of infants provides for more efficient use of available therapies rather than waiting for complications to develop. An additional example is enabling teachers to recognize developmental problems for early intervention.

Removing barriers such as stigma and discrimination that reduce incentives to knowing one's HIV status also realize program efficiencies as persons knowing their HIV+ are able adapt their risk behaviors accordingly. In addition, a person identified as HIV+ in Thailand has access to effective ART, which reduces the infectivity of that individual, again furthering prevention.

4.6 Monitoring and Evaluation System

4.6.1 Impact and outcome measurement systems

Describe the impact and outcome measurement systems, including strengths and weaknesses, used to measure achievements of the national disease program at impact and outcome level.

The *National AIDS Management Center* (NAMC) plays the role of the national HIV/AIDS M&E unit since its establishment in 2009. NAMC develops, implements, coordinates and maintains the national M&E plan and system in collaboration with other organizations within the MOPH and other ministries. MOSDHS is a key stakeholder for implementing and coordinating CABA- related programs. A national set of outcome and impact indicators are in use to guide M&E of program effort but are lacking in key CABA indicators. A list of HIV/AIDS indicators used to monitor the epidemic and the national response is presented in the National Strategic Plan: 2007-2011 the Universal Access Operational Plan, and the *Thailand National M&E plan for HIV Prevention 2010-2011.*

The existing sources of outcome and impact data are general population surveys, Multiple Indicator Cluster Survey (MICS), IBBS and targeted surveys for key MARP populations. National sentinel surveillance provides periodic monitoring. Routine program monitoring clinical settings, HMIS, captures service provision data in the health sector. Non-clinical settings has recently been added. Statistical models of size estimation is used for estimating the populations in need of different services.

The CABA as well as care and support impact and outcome monitoring system is still fragmented and in its early stages. The next MICS, previously carried out in 2005-2006, is an important opportunity to generate useful data at relatively low marginal cost. With appropriate technical and limited financial support, under the supervision of the National Statistics Office (NSO), it will be used for future measurements of impact and outcomes for CABA programs. For other reporting, Thailand's NHSO carries out surveys for the NAP database. Existing indicators reported to UNGASS for HIV prevention and treatment will be adjusted by disaggregating sex and age to also measure impact or outcomes for CABA.

The national HIV /AIDS program impact and outcome measurement systems has the following strengths: (a) through GFATM Round 8 support for MARPs, and linked national M&E system planning, Thailand has a clear M&E roadmap and well-conceived national M&E plan; (b) under NAMC, Thailand has a central M&E operating unit for HIV/AIDS that will integrate the remaining pieces, including treatment, care and support as well as CABA data; (c) through existing systems using the national database, and adjustments planned for the next MICS, Thailand can identify an efficient way forward to incorporate relevant indicators for CABA.

Notwithstanding, the emergent national CABA system has weaknesses also. Questions remain on the institutional framework: who is the lead coordinator and ultimate user of the data for CABA, and for example, which policy makers, which programmers and which line ministry should lead the data dissemination and use process. Linkages between MOPH and the MOSDHS are only beginning and technical challenges remain on how to best integrate HIV/AIDS data from the MOPH into existing child-focused data systems and vice versa. There is also a lack of established mechanisms for sharing data for CABA with data flow issues being more apparent at the provincial level with respect to the completeness, quality and timeliness of reporting. Provincial and lower level capacity for M&E and coordination for multi-sectoral responses is also still relatively weak and the system needs improvement in ensuring data consistency and use from the community to provincial to the national level. Through R10, a focus will be on

strengthening the national CABA M&E system. Each of these weak areas is addressed under Objective 4 in this proposal.

4.6.2 Impact and outcome measurement

(a) Has impact and/or outcome data been collected in the last 2 years?	☐ XYes → *answer section 4.6.2 (b)*	☐ No → *go to section 4.6.2 (c)*	(b) What was the source(s) of the measurement?	(c) *National AIDS Program Database* (d) *MICS* (e) *HIVQUAL*

(f) It is important to guarantee that there are systems in place to measure all impact and outcome indicators in the performance framework. In order to do this, fill in the table below, fully describing all planned surveys, surveillance activities and routine data collection in country used to measure impact and outcome indicators relevant to the proposal. Add rows as needed.

Data Source	Funding	Years of Implementation					Impact/Outcome Indicators relevant to the proposal to be measured by data source
		2011	2012	2013	2014	2015	
Source 1 **National AIDS Database (Enhanced analysis function)**	Total cost	**1.47**	**1.50**	**1.53**	**1.56**	**1.59**	**Impact No. 1:** % of Children with advanced HIV infection receiving ART (aged 15 and below)
	Secured funding amount and funding source	**1.47**	**1.50**	**1.53**	**1.56**	**1.59**	
	Funding gap	**0**	**0**	**0**	**0**	**0**	
	Round 10 funding request for Source 1	**0**	**0**	**0**	**0**	**0**	
Source 2 Multiple Indicators Cluster Surveys (MICS)	Total cost	**1.10**				**1.16**	**Impact No.2**: % of Children affected by HIV and vulnerable children aged 5-18 who reported improvement in their wellbeing **Outcome No.1:** % of orphaned and vulnerable children aged 0-17 whose household received free basic external support in caring for OVC (at least one) **Outcome No2**: % of women aged 15-49 expressing accepting attitudes towards family members infected with HIV
	Secured funding amount and funding source	**0.50**				**0.53**	
	Funding gap	**0.60**				**0.63**	
	Round 10 funding request for Source 2	**0.60**				**0.63**	
Source 3 HIVQUAL	Total cost	**1.01**		**1.05**		**1.09**	Outcome No.3: % of children who was born from HIV infected mothers received follow up on HIV status.
	Secured funding amount and funding source	**1.01**		**1.05**		**1.09**	
	Funding gap	**0**		**0**		**0**	
	Round 10 funding request for Source 3	**0**		**0**		**0**	

4.6.3 Links with the National M&E System

(a) Describe how the monitoring and evaluation (M&E) arrangements in the proposal (at the Principal Recipient, Sub-recipient, and other levels) use existing national indicators, data collection tools and reporting systems including reporting channels and cycles.

The PR with the assistance of SR Pact will systematically build on the existing national and provincial level capacity to add relevant M&E components for CABA the extent possible. The status of the national M&E system was described in Section 4.6.1. While the GFATM Round 10 will focus on a new target population, CABA, it will also ensure the linkages for each of the items below through both horizontal and vertical linkage activities:
Indicators will be based on the existing system with some minor adjustment for CABA on UNGASS system and the next MICS. New systems for care and support that link well with CABA data are under consideration at the national level. These will be leveraged and developed in Round 10.

Indicators will be developed to measure quality of life and/or well-being of CABA, and new data sets will developed by SR Pact to measure community systems strengthening outcomes. An attempt will be made to adapt existing outcome indicators, or when not available, as in the case of well-being, develop pilots that will be scaled up with national resources and incorporated into the next HIV/AIDS strategy.
Data collection tools will be based on existing tools used in RCC and Round8 that have been integrated into the national M&E system, with adjustments for CABA and for the focus on caregivers and children. Simplified tools for community-level reporting will be developed in Round 10 and shared with previous rounds.
Reporting systems will be channeled along the same lines as for the 2009 national M&E plan for HIV prevention, with important horizontal linkages to the MOSD/HP at the national and provincial levels.
New linkages will be made at the sub-district level and below. Child Action Groups at the community level will be trained on a pilot basis during Phase 1 in community-based M&E that links to the appropriate sub-provincial government authority. This training, a specialty area of Pact in Thailand, includes use of logic models to build ownership by community-based organizations, which in turn drive data collection and data use that is in full compliance with GFATM requirements but also owned and used by the program teams on the ground. Pilot grants will be used to develop this nascent M&E capability at the community systems level.

(b) Are all of the M&E arrangements planned for the proposal using the national M&E system?	☐ ⦿ Yes → *go to section 4.6.4*	☐ No → *continue to section 4.6.3 (c)*

(c) If no, explain why not and list any service delivery areas (SDAs) and/or activities that will not be monitored through the national M&E system.

ONE PAGE MAXIMUM

4.6.4 Strengthening monitoring and evaluation systems		
(a) Has a multi-stakeholder national M&E assessment been recently conducted (in last 2 years)?	☒ Yes → *continue to section 4.6.4 (b)*	☐ No → *go to section 4.6.5*
(b) If yes, has a costed M&E action plan been developed or updated to include identified M&E strengthening measures?	☐ ⦿ Yes → *continue to section 4.6.4 (c)*	☐ No → *go to section 4.6.5*
(c) Describe whether the proposal is requesting funding for any M&E strengthening measures. These strengthening measures may have been identified through a national M&E assessment or any other relevant evaluation or review process.		

The National M&E Plan for HIV Prevention for MAPPs and Migrant Workers was developed in February 2010. It identifies several M&E strengthening measures such as improving the routine HIS and surveillance systems, developing size estimations for MARPs, improving quality and use of evaluation data, developing M&E capacity locally, and increasing use of program evidence for policy making. While several of these measures are specific for HIV prevention, some of the measures are relevant for expanding and improving M&E for programming that aims to increase the well-being and quality of life of CABA

The HIV strengthening measures are costed (pp. 46-48) through March 2011. These initial costs developed previously will be used as a reference. NAMC has verified that additional funds are needed beyond 2011 specifically to expand and adapt the existing system for CABA programming. Many of the activities outlined in Objective 4 will be used to develop the existing M&E system capacity. Therefore, this proposal is requesting funding to develop the national M&E plan specifically in the following areas:

1) Support the implementation of the MICS, IBBS, sentinel surveillance, as well as size estimation- core systems for outcome/impact monitoring. Improve the estimation of the number of CABA in targeted provinces and priority sub-districts

2) Strengthening of routine program monitoring in non-clinical settings- community-based systems- including training in basic M&E skills for CBOs/NGOs/government

3) Improve the availability, quality and use of evaluation data for CABA at the national and provincial levels through standard setting, training around the standards, and development of a network of M&E practitioners focused on CABA. Strengthen data use by developing a regular mechanism/forum for data sharing and use at the community, provincial, regional and national levels- including task teams that meet regularly to review progress and use data for decision-making, planning including data triangulation.

4) At all levels, national to primary, ensure access to updated program information and evidence for policy making for CABA, especially the Child Protection Committee at the provincial levels

5) Develop M&E capacity, at the sub-provincial and community levels. Establish or strengthen existing institutional frameworks, coordination mechanism, and harmonization of M&E systems, including support to community-based M&E systems and capacity strengthening

4.7 Implementation Capacity

4.7.1 Principal Recipient(s)

Describe the technical, managerial and financial capacities of each Principal Recipient (PR) to manage and oversee implementation. Include any anticipated limitations to strong performance and refer to any existing assessments of the PR, other than Global Fund reporting mechanisms.

→ Copy and paste tables below if there more than three Principal Recipients

PR 1 Name	Department of Disease Control, Ministry of Public Health of Thailand	Sector	Government
Street Address	88/21 Tiwanond Road, Nonthaburi Province, Thailand, 10100		

The Department of Disease Control (DDC), is under the Ministry of Public Health with a mission to improve health and wellbeing of Thai population, especially those affected by major infectious diseases. The DDC manages the national HIV/AIDS program, involving prevention among at-risk populations as well as provision of treatment, care and support to those infected and affected by HIV and AIDS.

The DDC also provides technical support to national PMTCT and ART programs implemented by the Department of Health (DOH) and actively involved in health systems strengthening process in order to improve health outcomes. The National AIDS Management Center (NAMc) under the DDC is responsible for coordination and management of HIV/AIDS related monitoring and evaluation tasks.

The DDC has extensive experience in program and financial management and has served as Principal Recipients managing multiples rounds of GFATM grants since 2003. These include: Enhancing HIV Related Care and Treatment (ECAT) for HIV infected mothers, their partners and children; and the on-going Aligning Care and Prevention of HIV/AIDS with Government Decentralization to Achieve Coverage and Impact (ACHIEVED). The department has established the office of GFATM administration, i.e. Principal Recipient Administration Office which has been effectively managing GFATM funded projects through clearly established procedures and formalities which are: program and process with sub-recipient partnership; financial and accounting; procurement and supply management; and monitoring and evaluation. The DDC has clear financial organization structure. Roles and responsibilities within the financial team are clearly assigned and segregated with comprehensive policy and procedure on financial and procurement management to manage petty cash, advances, fixed assets, procurement and other financial matters. The DDC keeps records of the fixed assets both at the PR and sub-recipients and performs the physical count once a year. Budgets and workplans are formally agreed with the sub-recipients and disbursements are made to the sub-recipients based on the agreed budgets and work plans as well as the performance of the sub-recipients. The DDC has its own M&E system and structure with a growing team of M&E specialists and managers who have particular expertise in the definition of indicators, baselines and targets for and undertake monitoring and evaluation activities at the central and field level.

PR 2 Name	AIDS ACCESS FOUNDATION	Sector	Non-Government Organization
Street Address	48/282 Center Place Building Soi Ramkhumhang 104 SapanSoong distrct, Bangkok 10240		

AIDS ACCESS Foundation is a local civil society organization founded in 1991 to respond to HIV epidemics in Thailand. ACCESS's purpose is to make universal access to HIV prevention, treatment, care and support a reality in Thailand. The organization seeks to accomplish this through two pronged approach of direct program implementation in areas highly affected by HIV, and advocacy and dialogue with relevant national government bodies, policy makers and program planners. ACCESS has worked closely with TNP+ successfully in advocating for ARV production and sales under generic names and

working with the Government Pharmaceutical Organization (GPO) and the National Health Security Office (NHSO) for the inclusion of free ARV and treatment of OI under Thailand's Universal Health Coverage (UC) Scheme in 2005, resulting in increased access to HIV treatment among PLHIV in Thailand in a true sense. ACCESS has been working with key affected populations, i.e. the PLHIV groups in HIV counseling, treatment literacy and peer support; and building the country-wide network of people living with HIV/AIDS , the TNP+, who are now providing treatment support alongside government health care providers under the name Comprehensive Care Centers (CCC) in 70 provinces. The 'We Understand' group, an arm of ACCESS, has initiated a program providing psychosocial care to children born with HIV, developing positive roles, social involvement and increasing the capacity of families to care for children affected by HIV and AIDS.

ACCESS has received funding from both local and international sources for its own program implementation as well as managing sub-grants to other organizations. During 2003-2008, funded by GFATM's Round 1, as SR to DDC and as SSR to PATH, the ACCESS managed US$ 4,462,660 for HIV care and HIV/AIDS education components. Currently under the GFATM R1- RCC ACHIEVED (2008-2013) as SR under the DDC and as SSR under PATH, ACCESS managed grants of approximately US$ 519,578 for the period 2008-2010, working with 13 clusters of schools on HIV/AIDS education and providing sub-grant support to 382 PLHIV groups across the country. In addition to the GFATM grants, ACCESS has received and managed grants from other donors, including UNICEF, European Commission, MSF, ICCO, Oxfam UK, and the Ford Foundation. In 2010, the organization has received US$ 1,500,000 funding from the Thai NHSO to implement/manage nationwide public campaigns on HIV prevention.

ACCESS projects are implemented in accordance with the organization's written financial rules and regulations approved by the Foundation's Board. The financial, budgeting, and cash flow systems are robust with internal controls and external audits. The internal controls ensure segregation of duties, responsibilities and accountabilities. Each grant is held under separate bank accounts with different charge codes under the financial system.

ACCESS was selected to be the Civil Society PR based on its technical capacity in HIV care and support, experiences in working with families and communities, communication expertise, advocacy leadership, and demonstrated capability in program and financial management. Having worked collaboratively with both government and non-government organizations active in HIV work for nearly twenty years, ACCESS has strong working relationships with both government and non-government agencies.

CLARIFIED SECTION 4.7.2 (f)

4.7.2 Sub-recipients				
(a) Will Sub-recipients be involved in implementation?	☐ X Yes → *go to section 4.7.2 (c)*			
	☐ No → *go to section 4.7.2 (b)*			
(b) If no, why not?				
HALF PAGE MAXIMUM				
(c) If yes, how many Sub-recipients will be involved?	☐ 1-6	☑ 7-20	☐ 21-50	☐ 50+

(d) Are all Sub-recipients already identified?	☐ ⦿Yes → go to sections 4.7.2 (e) and (f)	☐ No → go to section 4.7.3

(e) List the identified Sub-recipients and describe:

- The work to be undertaken by each Sub-recipient;
- Past implementation experience of each Sub-recipient;
- Any challenges that could affect performance of each Sub-recipient as well as a mitigation strategy to address this.

PATH Thailand SR- PATH will assist PR-DDC in providing technical assistance in health system strengthening and will support the MSDHS in improving child development services in government and private orphanages through the development of training modules and prototypes of training materials and tools for use in various settings. PATH specializes in system strengthening, and has partnered with the Ministry of Health in building capacity and developing innovations in service delivery. During GF round 1 and R1-RCC, PATH has worked with the Ministry of Education in scaling up sexuality/HIV education as part of the school curriculum, and engaged private and government clinics in introducing youth PLHIV friendly HIV/RH services in ten provinces.

Department of Health (DOH) SR-DOH under the Ministry of Health will be responsible for rolling-out and linking the ANC/MCH/PMTCT services with male involvement and the case manager model in the target provinces. As part of Thai health system, the DOH is responsible for technical aspects of national PMTCT programs, including development of training curricula and training counselors for PMTCT program implementation; provision of ARV for infected pregnant women and infants, provision of formula milk for infants born to HIV positive mothers and follow up care of children born to HIV positive mothers.

Ministry of Social Development and Human Security (MSDHS) SR-MSDHS will work to improve policies, strengthen social protection guidelines, measures and mechanisms related to the welfare of vulnerable children in residential care and those in the communities. The MSDHS will step up collaboration with local government organizations, the Tambon Administration Organization (TAO), NGOs and civil society groups to provide social support, services and protection to all children in need. The Ministry of Social Development and Human Security (MSDHS) of Thailand is responsible for social protection, equitable support and welfare of vulnerable and disadvantaged populations.

PACT Thailand office SR-Pact will work with the NAMC, PRs, SRs and SSRs to strengthened national, provincial, district and sub-district information systems for improvement of services to vulnerable children. Pact is an international non-profit corporation with extensive experience in strengthening HIV/AIDS programs with a special focus on monitoring, evaluation reporting and learning (MERL.) In Thailand, under the 5 year US$20 Million US government funded Greater Mekong Regional program, Pact currently works with HIV and AIDS networks, NGOs, CBOs and nascent groups. As such, Pact has a strong in country TA and capacity development system.

Raks Thai Foundation (RTF) SR- RTF is responsible for providing technical assistance and training for organizations implementing community strategies on Community Systems Strengthening (CSS). The tasks include skills building for service delivery, advocacy, leadership and coordination. The RTF has been working with HIV/AIDS infected and affected children, families and communities for many years. The RTF has served as PRs for 3 GFATM grants for Thailand and serves as SRs for many grants.

Thai Network of People Living with HV/AIDS (TNP+) SR-TNP+ is responsible for managing stigma reduction activities. These include coordination and production of materials and media pieces for

community level education and public campaigns for local and national media. Founded in 1997, TNP+ has been active in advocacy for rights of PLHIV and access to HIV treatment and peer support counseling for HIV adherence. The network has conducted numerous public campaigns and produced many award winning media pieces, including the Red Ribbon Award in 2004 to educate the public on HIV/AIDS issues and access to HIV treatment.

Thai National AIDS Foundation (TNAF) SR-TNAF is responsible for management and implementation of community strategies in 2 provinces in the North East. TNAF currently manages HIV/AIDS activities in that region and is familiar with stakeholders and local CBOs working in the area. TNAF has implemented the GFATM funded ECAT project in 41 provinces in all regions of Thailand for 5 years (2004-2009). At present, under the GFATM RCC-R1, TNAF has continued working to improve community-based responses through working with TAOs to develop local HIV/AIDS intervention plans.

The Life Skills Development Foundation (TLSDF) SR-TLSDF is responsible for the implementation of community strategies in 2 provinces in the Upper North. TLSDF currently manages HIV/AIDS activities in the Northern Region and is familiar with stakeholders and local CBOs working in the area. Since 1999, TLSDF has implemented project supporting orphans and vulnerable children at community level.

Planned Parenthood Association of Thailand (PPAT) SR-PPAT is responsible for the implementation of community strategies in 6 provinces in the South. PPAT is a current SR under the DDC managing HIV/AIDS interventions among sex workers for GFATM round 8 in the Southern Region, and is familiar with stakeholders and local CBOs working in the area. PPAT's experience and background includes counseling, maternal and child health, family planning, and support for women and children affected by HIV. PPAT has worked with local TAOs to include health and social support services in their plans.

World Vision Foundation Thailand (WVFT) SR-WVFT is responsible for the implementation of community strategies in 13 provinces in the Central Region. The WVFT head office is located in Bangkok and is managing and supporting HIV/AIDS-related projects in these locations. WVFT has worked with the MSDHS in providing assistance to families affected by HIV with income generation support, sales of products made by PLHIV and educational support for vulnerable children. As for the GFATM and HIV program management experience, WVFT has worked as SR for round 2 ECAT, and SSR for RCC-R1 and as SSR for round 8. WVFT has also served as PR and SSR for GFATM-supported TB grants to Thailand.

AIDSNet SR-AIDSNet is responsible for implementing community strategies in 5 Northern provinces, including the work with children of ethnic minorities. AIDSNet has long experiences in HIV/AIDS interventions in the region both on direct implementation and managing sub-grants among local CBOs and PLHIV groups. The agency has experiences in working with both Thai and ethnic minorities, and developed strong relationship with government and non-government organizations. AIDSNet is a current SSR to PPAT under GFATM round 8.

Plan Thailand SR-Plan is responsible for implementing community strategies in Bangkok. Plan Thailand is an operating arm of Plan International and has been working in Thailand for more than 20 years. Plan Thailand's HIV program includes HIV prevention among youth, impact mitigation through income generation support, and community mobilization. The organization has strong program and grant management experience, managing grants to 15 CBOs. Regarding GFATM experience, Plan Thailand is an SSR of the TB-HIV program of Round 8.

(f) If the private sector and/or civil society are not involved as Sub-recipients in implementation, or only involved in a limited way, explain why.

The private sector is not involved as Sub-recipients but has indicated the willingness to support Global Fund Round 10 as described in section 4.4.6 as followed:

- Thai Public Broadcasting Services (TPBS) TV will contribute broadcasting time for the documentary series developed by the TNP+ (Objective 3, SDA 3.2, Activity);
    - The series will be also shown on local Cable TV in at least ten provinces at no charge.
    - In addition, over 50 community radio stations will use script of the series developed by TNP+ in their broadcasting at no charge.
    - With this contribution, the series will reach no less than 200,000 people.
- PATH and Chevron-Thailand will contribute to parenting education and youth peer-to peer activities in at least four southern provinces (Objective 2, SDA 2.2, and Activity 2.2.1).
- Rotary-Thailand will replicate education materials for vulnerable children(Objective 2, SDA 2.2, Activity 2.3.1)

Apart from above private sectors, the Joint Strategic Planning Committee of the Round 10 proposal will also manage to get contributions in funds and in kind from foundations and private companies already funding child welfare initiatives the intervention areas and the advocacy campaign for reducing stigma.

4.7.3 Sub-recipients to be identified

Describe:

(a) why some or all of the Sub-recipients are not already identified; and

(b) the transparent, time-bound process that the Principal Recipient(s) will use to select Sub-recipients and not delay program performance.

ONE PAGE MAXIMUM

4.7.4 Coordination between or among implementers

Describe:

(a) how coordination will occur between multiple Principal Recipients if there is more than one nominated Principal Recipient for the proposal; and

(b) how coordination will occur between each nominated Principal Recipient and its respective Sub-recipient to ensure timely and transparent program performance.

PR-Access and PR-DDC will be working together to shape and steer the overall project and ensure program synchronization through a Joint Strategic Committee (JSC) which will be comprised of the 2 PRs and 12 SRs (4 SRs under PR-DDC and 8 SRs under ACCESS-PR). The Chair of the JSC will be appointed by the CCM. Designated member(s) of Technical Committee-HIV of the CCM, as well as key members of the NAP representing ministries involved will be invited to participate in two JSC meetings a year to ensure connection and harmonization with the overall National Program. The JSC will meet quarterly, with two of the meetings each year being the expanded-JSC.

At the national level, there are overlapping concerns and mandates among Ministries of Health, Education, Human Resource and Social Development re. HIV and child protection policies and a number

of redundant committees with youth development agendas The Project will work through MHSD (under PR-DDC), who hold the budget for national coordinating fora, will convene annual meetings to ensure the coordination and linkages of these key actors. The strategic Information system developed by the Project (under PACT and NMAC) will serve as a key tool to bring these ministries and their committees together to harmonize their plans at national and provincial levels

At the provincial level, the PR-DDC will build upon the existing Provincial Coordinating Mechanism (PCM) which is a platform, created in RCC, and joined by the GF Round 8, to bring attention and sustainable support to children affected by HIV/AIDS in the targeted provinces. PR-DDC will instruct the PCM to facilitate linkages of relevant actors in SRs/SSRs with the Provincial Child Protection Committee (CPC), a standing body which is multi-sectoral, and multi disciplinary, chaired by the Governor. This joint working group of PCM and PCP will meet twice a year to review and steer the efforts of GF-10 implementing partners in harmonization with the National Children and Youth Development Plan (2003-2012). Meanwhile, the Provincial SSRs (Under PR-ACCESS) will link with PCM to assure a common agenda the CAGs to advocate for child support and protection issues that need to be dealt with at the provincial level through the platform of PCM and CPC.

In addition, regular CAG meeting which will be convened by the Provincial SSRs in each TAO on a monthly basis. Provincial SSRs also will convene meetings of CAGs (clustered by district) and health, education, and social services at the district level on a quarterly basis. This forum will assure coordination and integration of operational issues addressing both health and social protection support to the targeted children and youth.

A planning process will be initiated by the two PRs within two weeks of the notification that the RD 10 proposal submitted by Thailand has been approved by the Global Fund. Planning templates for the PRs, SRs and SSRs will be developed and plans for the Project will be developed in consultation with local leaders and civil society organizations. These plans for GF-Rd 10 will include a description of activities, performance targets, indicators, monitoring and evaluation methodologies, a work plan and budget The PRs will present these plans for the Round 10 activities at the first meeting of the JSC. Following approval of the PR, SR, and SSR project plans, the functional planning instruments will be quarterly work plans and budgets. Quarterly program and expenditure reports will be summarized at the quarterly JSC meetings.

Since the overall M&E framework of the two PRs is managed under one SR-PACT, PACT will assist the two PRs in developing tools to track program progress and address this in all SRs meetings and detect areas that are underachieveing and need focus or strategic fine tuning. In addition, PACT will develop training modules for the SRs and SSRs in planning, evaluation and monitoring, convene training sessions and offer consultation as needed.

CLARIFIED SECTION 4.7.5 : The applicant is asked to submit a detailed technical assistance plan once it becomes available.

4.7.5 Strengthening implementation capacity

(a) The applicant is encouraged to include a funding request for management and/or technical assistance to achieve strengthened capacity and high quality services, supported by a summary of a technical assistance (TA) plan based on the indicative percentage range in the Guidelines. In the table below provide a summary of the TA plan.

→ Refer to the Strengthening Implementation Capacity information note for further background and detail

ROUND 10 - HIV

TA plan to strengthen PR Access program and financial management capacity				
Management and/or technical assistance **need**	Management and/or technical assistance **activity**	**Intended beneficiary** of management and/or technical assistance	Estimated timeline	Estimated cost *→ same as proposal currency*
Sub-recipient capacity assessments	Provide coaching and technical support to PR-Access to assess the capacity of all sub-recipients and SSRs.	PR Access, the sub-recipients, and ultimately the communities served.	Q1 through Q2.	$7200
PR standard operating procedures for sub-grants management	Review and upgrade SOPs for pre-award assessments, grant negotiation documentation, grant monitoring procedures and controls.	PR Access, the sub-recipients, and ultimately the communities served.	Q1 and Q2	$7200
Financial systems of PR-Access and all SRs, SSRs	Systems check for controls, documentation, and sampling for potential areas of weakness, as part of pre-award review process	PR Access, the sub-recipients, and ultimately the communities served.	Q1 and Q2	$13,200

(b) Describe the process used to identify the assistance needs listed in the above table.

SR Pact provided a briefing on capacity strengthening and service delivery improvement at an August meeting of R10 PRs and SRs. The Pact management assessment tool, OCA, was distributed to participants. The process of team-based participatory assessments was also explained. Each participant discussed the meaning of the various criteria in the tool to clarify any terminology that might cause confusion. Subsequent to the meeting, each participant returned to its main office, and using a multi-functional team process, rated itself on a 0-3 scale across a sub-set of critical management areas such as planning, organizational structure, program management, M&E, financial management, and human resource management. Pact program officers were made available to support the self assessments. A senior Pact official reviewed the documentation and set up meetings to triangulate the self-assessment rankings with evidence of achievement. For each participant, a list of key strengths and weaknesses were identified. The cohort of PRs and SRs were analyzed by the Pact team, and the resulting TA plan is based on the most widely cited weaknesses in need of strengthening.

In addition to the OCA assessment, a separate set of tools was applied by an independent consultant to assess the capacity or PR-Access. This tool was based on an adaptation from the LFA tools for PR assessments provided by GFATM. Pact reviewed the work of the independent consultant and documented areas in need of further explanation, and evidence needed to substantiate the review.
In consultation with the independent consultant and the PR team leader, the TA plan was designed by the Pact officer and updated with requests from other SRs and potentially SSRs. Pact is an INGO that has decades of experience in management, efficient grant-making and service delivery capacity assessments (technical and organizational capacity) for NGOs and it will be available to provide the

needed TA or to supervise provision of local TA providers.
(c) If no request for management and/or technical assistance is included in the proposal, provide a justification below. Or, if the funding request is outside the indicative percentage range, provide a justification below.
HALF PAGE MAXIMUM

4.8 Pharmaceutical and Other Health Products

4.8.1 Scope of Round 10 proposal	
Does the proposal seek funding for any pharmaceutical and/or health products?	☐ Yes → *go to section 4.8.2*
	☐ ⦿ No → *skip the remainder of section 4.8*

4.8.2 Table of roles and responsibilities			
unction	Name of the organization(s) responsible for this function	Role of the organization(s) responsible for this function	Does the proposal request funding for additional staff or technical assistance? → *indicate Yes or No*
Procurement policies, systems, and planning			
Intellectual property regulations			
Quality assurance and quality control			
Management and coordination → *more details required in section 4.8.3*			
Product selection (e.g. PMTCT and pediatric HIV care)			
Management Information Systems (MIS)			
Forecasting			
Storage and inventory management → *more details required in section 4.8.4*			
Distribution to other stores and end-users → *more details required in section 4.8.4*			
Ensuring rational use and patient safety			
Pharmacovigilance			
Drug resistance Surveillance			

4.8.3 Past management experience

Describe the past experience of each organization that will be involved in managing pharmaceutical and other health products.

Organization name	Short description of management experience	Total value procured during last financial year → *same currency as proposal*
→ *use the 'Tab' key to add extra rows*		

4.8.4 Alignment with existing systems

Describe how the proposal uses existing country systems for the management of the additional pharmaceutical and health product activities that are planned, including pharmacovigilance and drug resistance surveillance systems. If existing systems are not used, explain why.

ONE PAGE MAXIMUM

4.8.5 Storage and distribution systems

(a) Which organization(s) have primary responsibility to provide storage and distribution services under the proposal? → *tick the corresponding boxes to the right and enter the name of the organization(s)*	☐ National medical stores or equivalent
	→ *specify*
	☐ Sub-contracted national organization(s)
	→ *specify*
	☐ Sub-contracted international organization(s)
	→ *specify*
	☐ Other:
	→ *specify*

(b) For storage partners, what is each organization's current storage capacity for pharmaceutical and health products? If the proposal represents a significant change in the volume of products to be stored, estimate the relative change in percent, and explain what plans are in place to ensure increased capacity.

ONE PAGE MAXIMUM

(c) For distribution partners, what is each organization's current distribution capacity for pharmaceutical and health products? If the proposal represents a significant change in the volume of products to be distributed or the area(s) where distribution will occur, estimate the relative change in percent, and explain what plans are in place to ensure increased capacity.

ONE PAGE MAXIMUM

4.8.6 Pharmaceutical and health products for initial two years

Complete the Pharmaceutical and Health Products List and list all of the products that are requested to be funded through the proposal.

If the pharmaceutical products included in the Pharmaceutical and Health Products List are not included in the current national, institutional or World Health Organization Standard Treatment Guidelines (STGs), or Essential Medicines Lists (EMLs), describe below the STGs that are planned to be utilized, and the rationale for their use.

Applicants are invited to justify the prices based on either the range provided in the Unit Costs for Selected Key Health Products information note or with another published international reference source. If the provided price is out of range, provide justification. Also, if local legislation is preventing access to low cost prices through local manufacturers or similar mandates, clarification should be provided as well as a plan for addressing such barriers over the life of the proposal.

ONE PAGE MAXIMUM

4.8.7 Multi-drug resistant tuberculosis

Is the provision of treatment of multi-drug resistant tuberculosis included in this HIV proposal as part of TB/HIV collaborative activities?	☐ Yes → *include USD 50,000 per year over the full proposal term to contribute to the costs of Green Light Committee Secretariat support services*
	☐ No → *do not include the Green Light Committee costs*

4B. CROSS-CUTTING HSS - PROGRAM DESCRIPTION

Read the Round 10 Guidelines to consider including optional cross-cutting HSS interventions

SECTION 4B can only be included in the Round 10 HIV proposal if:

- the applicant has identified gaps and constraints in the health system that have an impact on HIV, tuberculosis and malaria outcomes;
- the interventions required to respond to these gaps and constraints are 'cross-cutting' and benefit more than one of the three diseases (and potentially benefit other health outcomes); and
- section 4B is not included in the Round 10 tuberculosis or malaria proposal.

Section 4B can be downloaded from the Global Fund's website if the applicant intends to apply for cross-cutting HSS.

5. FUNDING REQUEST

The Round 10 Guidelines contain different guidance for sections 5.1 and 5.2 depending on whether the applicant selected Option 1, 2 or 3 in section 3.1 of the Proposal Form

Option 1 = Transition to a single stream of funding by submitting a consolidated disease proposal

Option 2 = Transition to a single stream of funding during grant negotiation

Option 3 = No transition to a single stream of funding in Round 10

5.1 Financial Gap Analysis

Section D and H of the Gap Analysis table below must be completed differently depending on whether applicant selected Option 1, 2 or 3 (see above)

→ *Summary Information provided should be described further in sections 5.1.1 - 5.1.3*
→ *Currency must be the same as identified on the proposal cover page*
→ *Adjust the years as necessary in the table from calendar years to financial years to align with national planning and fiscal periods*

Financial gap analysis								
	Actual		Planned		Estimated			
	2008	2009	2010	2011	2012	2013	2014	2015
SECTION A: Funding needs for the full national HIV program								
LINE A → *Provide annual amounts*	**437,540,954**	**502,468,112**	**456,212,740**	**621,303,828**	**660,955,741**	**704,572,845**	**752,511,660**	**805,328,355**
LINE A.1 → *Indicate the amount of the funding need for the full national HIV program over the full term of the Round 10 proposal*								**3,544,672,429**
SECTIONS B, C AND D: Current and planned resources to meet the funding needs of the full national HIV program								
Section B: Domestic								
Domestic source **B1**: Loans and debt relief → *provide name of source here*	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Financial gap analysis								
	Actual		Planned		Estimated			
	2008	2009	2010	2011	2012	2013	2014	2015
Domestic source B2 National funding resources	**184,906,250**	**210,156,250**	**227,843,250**	**250,627,575**	**295,666,553**	**325,233,208**	**357,756,529**	**393,532,181**
Domestic source B3 Private sector contributions (national)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
LINE B: Total current & planned DOMESTIC resources → *Total of Section B entries*	**184,906,250**	**210,156,250**	**227,843,250**	**250,627,575**	**295,666,553**	**325,233,208**	**357,756,529**	**393,532,181**
Section C: External (non-Global Fund)								
External source C1 *USCDC (TUC)*	**2,529,620**	**1,689,284**	**2,326,151**	**1,515,180**	**1,500,000**	**1,500,000**	**1,500,000**	**1,500,000**
UNAIDS	**58,962**	**271,579**	**192,415**	**76,185**	**N/A**	**N/A**	**N/A**	**N/A**
UNICEF	**509,148**	**436,819**	**1,095,500**	**1,188,026**	**N/A**	**N/A**	**N/A**	**N/A**
WHO	**239,603**	**353,973**	**119,000**	**119,000**	**N/A**	**N/A**	**N/A**	**N/A**
UNFPA	**429,104**	**401,674**	**401,674**	**361,507**	**N/A**	**N/A**	**N/A**	**N/A**
UNDP	**15,000**	**34,000**	**50,000**	**50,000**	**N/A**	**N/A**	**N/A**	**N/A**
USAID/RDMA	**1,292,008**	**1,202,009**	**1,182,010**	**1,232,011**	**N/A**	**N/A**	**N/A**	**N/A**
World Bank	**112,218**	**60,200**	**72,675**	**130,815**	**87,210**	**N/A**	**N/A**	**N/A**
IOM	**44,482**	**9,240**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
UNESCO	**53,102**	**54,602**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
PLAN	**425,257**	**289,293**	**295,584**	**310,957**	**25,000**	**25,000**	**N/A**	**N/A**
UNIFEM	**20,000**	**100,574**	**45,000**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
External source C3 Private sector contributions (International)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Financial gap analysis								
	Actual		Planned		Estimated			
	2008	2009	2010	2011	2012	2013	2014	2015
LINE C: Total current & planned EXTERNAL (non-Global Fund) resources *→ Total of Section C entries*	**5,728,504**	**4,903,246**	**5,780,009**	**4,983,681**	**1,612,210**	**1,525,000**	**1,500,000**	**1,500,000**
Complete this version of Section D if the applicant selected Option 2 or 3 in section 3.1 of the Proposal Form: Section D: External (Global Fund) *→ Insert additional lines below if there are more than two existing HIV Global Fund grants*								
Grant D1 *R1-RCC*	**0**	**18,315,481**	**17,766,828**	**19,782,938**	**15,290,607**	**13,844,332**	**13,017,192**	**0**
Grant D2 *R2*	**3,442,828**	**821,178**	**0**	**0**	**0**	**0**	**0**	**0**
Grant D3 *R8*	**0**	**2,181,244**	**24,812,434**	**26,582,443**	**31,211,649**	**31,746,712**	**27,888,538**	**0**
LINE D: Total current & planned EXTERNAL (Global Fund) resources *→ Total of Section D entries*	**3,442,828**	**21,317,903**	**42,579,262**	**46,365,381**	**46,502,256**	**45,591,044**	**40,905,730**	**0**
Complete this version of Section D if the applicant selected Option 1 in section 3.1 of the Proposal Form: Section D: External (Global Fund) *→ Insert additional lines below if there are more than two existing HIV Global Fund grants*								
Section D1: Grants not included in consolidated disease proposal Grant D1-A *→ provide grant number here*								
Grant D1-B *→ provide grant number here*								
Section D2: Grants included in consolidated disease proposal and listed in section 3.1(b) Grant D2-A *→ provide grant number here*								

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Financial gap analysis								
	Actual		Planned		Estimated			
	2008	2009	2010	2011	2012	2013	2014	2015
Grant D2-B → *provide grant number here*								
LINE D: Total current & planned EXTERNAL (Global Fund) resources → *Total of Section D entries*								
LINE E : Total current and planned resources → *Line E = Line B + Line C + Line D*	**194,077,582**	**236,377,400**	**276,202,521**	**301,976,637**	**343,781,019**	**372,349,252**	**400,162,259**	**395,032,181**
Calculation of gap in financial resources and summary of total funding requested in Round 10 → *must be supported by detailed budget*								
LINE F: Total funding gap Line F = Line A - Line E	**243,463,371**	**266,090,712**	**180,010,219**	**319,327,191**	**317,174,722**	**332,223,593**	**352,349,401**	**410,296,174**
LINE G: Round 10 HIV funding request → *must be same amount as requested in tables 1.1, 5.3, 5.4 and detailed budget for this disease*				**7,137,026**	**8,261,221**	**9,961,885**	**10,515,019**	**6,213,416**

Part H - Cost Sharing calculation for Lower-middle income <u>and</u> Upper-middle income applicants	
In Round 10, the total maximum funding request for HIV in Line G is: (a) For **Lower-Middle income countries**, an amount that results in the Global Fund's overall contribution (all grants) to the national program being not more than 65% of the national disease program funding needs over the proposal term; and (b) For **Upper-Middle income countries**, an amount that results in the Global Fund overall contribution (all grants) to the national program being not more than 35% of the national disease program funding needs over the proposal term.	
Line H = Cost Sharing calculation as a percentage (%) of overall funding from Global Fund Complete this cost sharing calculation if the applicant selected Option 2 or 3 in section 3.1 of the Proposal Form: *Cost sharing = (Total of Line D amounts for proposal period + Total of Line G amounts) X 100 / Line A.1* Complete this cost sharing calculation if the applicant selected Option 1 in section 3.1 of the Proposal Form: *Cost sharing = (Total of Line D1 amounts for proposal period + Total of Line G amounts) X 100 / Line A.1*	6.2 %

5.1.1 Explanation of financial needs and additionality of Global Fund financing

Describe how the annual amounts were:

(a) developed;
(b) budgeted in a way that ensures that government, non-government and community needs were included to reflect implementation of the country's malaria program strategies; and
(c) developed in a way that demonstrates the funding requested in the proposal will contribute to the achievement of outputs and outcomes that would not be supported by currently available or planned domestic resources.

(a) *how the annual amounts were developed*

The financial needs of HIV prevention, treatment, care and support program in Thailand are described in the National Universal Access Work Plan for HIV and AIDS Prevention and Alleviation 2007-2011 (*'National UA Plan'*). The Plan provides the overall Goal, illustrates the strategies and details out the activities. The plan was developed considering data from various studies conducted over an extended period of time. Thailand uses the Asian Epidemic Model for estimation of the size of the HIV population. This estimation forms the basis for development of an annual budget. The Plan is based on an assumption of achievement of Universal Access for HIV prevention, treatment, care and support within the five year period. Four key strategies were identified in the *'National UA plan'*. These become the basis for formulation of budgets and estimates. The activities detailed out in the budget are costed based on the unit cost prescribed by the Royal Thai Government. The processes adopted for arriving at the financial needs are:

1. Identifying the needs, targets, strategic plans
2. Detailing out the activities
3. Linking activities with unit costs to develop the budget.

The financial needs for Years 2012-2015 have been estimated by adding 10% to each prior year budget for treatment and care to take into consideration new infections and inflation. However, Thailand is in the process of developing the next Five Year National Strategic Plan and associated costed workplan, so some of these figures may be adjusted accordingly.

(b) how the annual amounts were budgeted in a way that ensures that government, non-government and community needs were included to reflect implementation of the country's program strategies

The *'National UA Plan'* and the budget estimate were prepared after extensive consultations involving government organizations, NGOs, community representatives, international organizations and academics. These consultations were held during a series of workshops during which time current and future needs were identified. The agreed upon plans were then approved by the National AIDS Committee which incorporates both government and civil society prior to being formalized into the National Plan for Strategic and Integrated HIV and AIDS Prevention and Alleviation.

(c) *how the annual amounts developed in a way that demonstrates the funding requested in the proposal will contribute to the achievement of outputs and outcomes that would not be supported by currently available or planned domestic resources*

The financial needs over the full term of the Round 10 proposal are estimated at 3,544 million USD. Current domestic resources including funding from prior rounds of the Global Fund amount to 183.6 million USD. This clearly indicates the funding gap for Thailand, particularly in the area of care and support for children affected by HIV and AIDS, for which actual expenditure was only 4-5% of total expenditures for HIV and AIDS.

5.1.2 Domestic funding *ONE PAGE MAXIMUM*

→ corresponds to LINE B in Table 5.1

Describe the processes used in country to:

(a) prioritize domestic financial contributions to the national HIV program including HIPC [Heavily Indebted Poor Country] and other debt relief, and grant or loan funds that are contributed through the national budget; and
(b) ensure that domestic resources are used efficiently, transparently and equitably, to help implement treatment, prevention, care and support strategies at the national, sub-national and community levels.

(a) The recent study on the National Expenditure on HIV and AIDS (National AIDS Spending Assessment: NASA) for 2008-09 indicates that in 2008, 85% and in 2009, 93% of the funding for the overall country HIV disease component came from domestic sources. It also indicates that there is clear prioritization of the funding. As per the NASA report, government has prioritized care and treatment with 76% of the HIV/AIDS budget directed to that sector, with only 14% of the total budget spent on HIV prevention. Orphans and vulnerable children, the category closest to the target population of this proposal, however, is considerably underfunded with only 1% of the overall HIV/AIDS budget allocated to this population group, despite the large numbers of children born to HIV-infected women every year (approximately 6,200 – AEM 2009).

(b) The Country has adopted a decentralized functioning method to deliver its program to respond to specific needs of each locality. The funds from the national government are sent to the provinces and also to local administration organizations. The local administration at provincial level is charged with allocating its HIV funding to best suit local community needs. This ensures that the planning process is democratic and takes into account the needs of the community. Spending is tracked against the plan, ensuring effectiveness of the usage of funds. In addition at the local administration level, there are councils whose role is to plan for, and monitor resources used at the local level.
The country adheres to a stringent audit and review mechanism. This includes:
(a) Audits that are conducted by the Office of Auditing General at all levels of governmental administration. These audits are held annually. In addition there is a system of internal audit at each level done by the Ministry of Interior. The audits ensure that funding received is accounted for properly.
(b) A mid term review of the National HIV/AIDS Plan is also conducted to measure progress of the program and review financial spending. There are studies proposed within the current application that will indicate effectiveness of the funds being used by the organizations for children affected by HIV/AIDS and other vulnerable populations.
(c) Donors also conduct regular reviews of the effectiveness of the use of funds. In addition there is a mechanism which requires the organization receiving funds to send a semi annual/annual (as per the requirement of the program) to the Province and National bodies for review.

5.1.3 External funding *ONE PAGE MAXIMUM*

→ corresponds to LINE C in Table 5.1

Describe:

(a) any changes in contributions anticipated over the proposal term and the reason for any identified reductions in external resources over time; and
(b) any current delays in accessing the external funding identified in Table 5.1 that should be explained, including the reason for the delay, and plans to resolve the issue(s).

a) There are no anticipated changes in contributions over the proposal term. The current funding cycle comes to an end at the end of 2011. External funding from various organizations continues

until end 2011 as well. The Royal Thai Government is in the process of formalizing the National AIDS Strategic Plan and determining funding requirements to fulfill its mandate. External resources shall be tapped. However, as indicated earlier the domestic funding contribution for 2009 was 93%, and as such the need for external funds is limited to the gap identified. It is within this reality that this proposal to the Global fund is being submitted.

b) No delays are envisaged in accessing external funds. The government has a prudent mechanism of involving all stakeholders in management of programs. The Government of Thailand maintains excellent relationships with partners and there is nothing that would suggest a delay in accessing external funding based on previous experience.

5.2 Detailed Budget

Instructions for completion of the detailed budget:

→ For guidance on the level of detail required (or for a template) refer to the budget information available in Section 5.2 of the Guidelines

1. Submit a detailed budget in Microsoft Excel format.
2. Ensure that this detailed budget is consistent in numbering with the Round 10 interventions in section 4.4.1 of the Proposal Form, the Performance Framework, and the detailed work plan.
3. From the detailed budget, prepare table 5.3, the summary by objective and service delivery area.
4. From the detailed budget, prepare table 5.4, the summary by cost category.
5. Do not include a request for CCM or Sub-CCM funding in this Round 10 proposal. Requests for funding are available through a separate application. The application is available at: http://www.theglobalfund.org/en/ccm/

5.3 Summary of Detailed Budget by Objective and Service Delivery Area

→ Use the same objective and SDA numbering as the description in section 4.4.1, the Performance Framework, and the detailed budget and work plan.
→ Annual totals at the end of this table must equal annual totals in the detailed budget and tables 1.1 and 5.4

Objective number	Service delivery area	Year 1	Year 2	Year 3	Year 4	Year 5	Total
1	Health System Strengthening	1,257,862	919,479	897,156	898,621	711,342	**4,684,460**
1	Community System Strengthening	443,830	583,128	935,473	657,103	581,250	**3,200,784**
1	Social protection system strengthening	133,888	162,630	226,161	220,755	220,755	**964,188**
2	Health System: Service Delivery	2,184,961	2,257,584	2,859,121	2,885,417	2,577,062	**12,764,146**
2	Community System Service delivery	1,706,240	2,961,440	3,745,216	4,850,333	901,460	**14,164,689**
2	Social support: Service Delivery	131,203	330,141	666,938	10,875	-	**1,139,156**
3	PLHIV leadership in stigma reduction	93,417	147,616	44,384	363,259	-	**648,677**
3	Promoting Stigma Reduction by Mass Media	26,880	77,813	50,317	13,594	13,594	**182,197**
4	HSS: Information system	434,449	370,885	386,612	403,118	420,432	**2,015,495**
4	M&E capacity development and data use	39,891	103,600	103,600	90,038	25,616	**362,744**
4	Operational Research , evaluation and selected studies	684,406	346,906	46,906	121,906	761,906	**1,962,031**
Round 10 HIV funding request:		**7,137,026**	**8,261,221**	**9,961,885**	**10,515,019**	**6,213,416**	**42,088,567**

5.4 Summary of Detailed Budget by Cost Category

→ Summary information provided in the table below should be described further in sections 5.4.1 to 5.4.3
→ Annual totals at the end of this table must equal annual totals in the detailed budget and tables 1.1 and 5.3

Cost Category	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Human resources	1,915,394	2,008,713	2,269,824	2,380,819	2,497,260	**11,072,010**
Technical and management assistance	274,501	317,739	383,149	404,424	238,978	**1,618,791**
Training	1,630,494	2,764,272	4,007,116	4,785,222	200,283	**13,387,386**
Health products and health equipment	-	-	-	-	-	**-**
Pharmaceutical products (medicines)	-	-	-	-	-	**-**
Procurement and supply management costs	-	-	-	-	-	**-**
Infrastructure and other equipment	205,625	-	-	-	-	**205,625**
Communication materials	220,109	206,827	175,302	358,252	13,594	**974,082**
Monitoring & Evaluation	1,070,029	812,858	922,045	952,108	1,527,686	**5,284,725**
Living support to clients/target populations	120,328	308,391	666,938	-	-	**1,095,656**
Planning and administration	1,700,547	1,842,422	1,537,512	1,634,195	1,735,616	**8,450,291**
Overheads	-	-	-	-	-	**-**
Other (specify):	-	-	-	-	-	**-**
Round 10 HIV funding request:	**7,137,026**	**8,261,221**	**9,961,885**	**10,515,019**	**6,213,416**	**42,088,567**

5.4.1 Overall budget context *HALF PAGE MAXIMUM*

Describe any significant variations in cost categories by year, or significant five year totals for those categories.

There are no significant variations in the cost categories other than that planned in the proposal. The scaling up of interventions and coverage of targets is planned is a phased manner which is reflected in the increased % of fund in year 2, 3 and 4. Cost escalation is estimated at 5% annually. There are specific cost categories of monitoring and evaluation communication materials which has an increase to 31% in the year 4. This is predominantly because of revision and reprinting of material envisioned in Year 4. Funding requests for living support to target population ends in Year 3 as it is anticipated that funding for this will be absorbed by Thailand from Year 4. This has been reflected in the Performance framework as well.

5.4.2 Human resources *HALF PAGE MAXIMUM*

(a) Describe how the proposed financing of salaries, compensation, volunteer stipends, or top-ups will be consistent with agreed in-country salary frameworks, such as national salary or inter-agency frameworks.

→ Attach supporting information as evidence, including draft documents where applicable

Budgeting for human resources is based on National Costing guidelines. Salaries and compensation are all based on the national plan and guidelines issued by the Ministry of Health. Where no national guidelines exist, market rates have been utilized for budgeting. Total funding for human resources is estimated to be 27% of the total funding requested across 5 years. There are two distinct types of stakeholders involved in the implementation of the proposal. There are Government-led agencies as PR, SR and SSR and there are civil society agencies for PR, SR and SSR. The salary structure for all government agencies have been budgeted as per the standards of the remuneration set by the Government. Civil society agencies have agreed to a different salary structure than Government staff for this proposal, however it is important to note that these have been budgeted reasonably. A separate sheet has been provided to indicate the salary costs. The number of positions and the designations has also been made to be consistent with the requirements of the role to be performed by staff of each of the agencies.

(b) In cases where human resources represents an important share of the budget, summarize: (i) the basis for the budget calculation over the initial two years; (ii) the method of calculating the anticipated costs over years three to five; and (iii) to what extent human resources spending will strengthen service delivery. *HALF PAGE MAXIMUM*

→ Attach supporting information as evidence, including draft documents where applicable

27% (11 million USD) of the funding request is estimated for human resources. The basis of calculation for human resources is based on the roles to be performed by each of the agencies and levels of expertise required. A combination of Government and civil society agencies is proposed to implement the activities. It should be noted that government agencies are deployed to implement the programs as part of their normal activities and that the only human resource costs budgeted for these staff is for work performed beyond normal responsibilities (e.g. overtime).

Most staff hired will be with SSRs and will be hired in Years 1 and 2 (2 positions per SSR per province). There will be one additional staff hired per SSR per province in Year 3 to Year 5 as the Project expands. An annual cost escalation of 5% per year is proposed in salary costs to accommodate cost of living increases.

The current proposal reaches out to 1,860 Tambons (sub-districts) across 29 provinces. The geographic diversity of the target area demands deployment of human resources to ensure that the reach is achieved. Health care providers and institutions play an important role in building of community systems in terms of service delivery. There are an estimated 255 centers to be reached which include hospitals, health centers, and institutional care. In order to effectively use the funds allocated to human resources, it is proposed that government infrastructure be utilized wherever possible to carry out funded activities. However, the overall reach of the proposal cannot be reached solely by existing government staff and it is therefore required that some existing staff be hired to build future sustainable capacity.

CLARIFIED SECTION 5.4.3

5.4.3 Other large expenditure items

If 'other' cost categories represent important amounts in the summary in table 5.4, (i) explain the basis for the budget calculation of those amounts; and (ii) explain how this contribution is important to implementation of the national HIV program.

→ Attach supporting information as evidence, including draft documents where applicable

There is no expenditure for this proposal in 'other' cost category.

5.4.4 Measuring service unit cost and cost effectiveness *HALF PAGE MAXIMUM*

Provide the following:

(a) where available, estimates of recent average service delivery unit costs at the program-level for key services with an explanation of how the estimates were developed;
(b) estimates of the expected average service delivery unit costs for key services that are included in the proposal; and
(c) a description of how key service delivery unit costs will be measured at the program-level, over time throughout the lifecycle of the grant.

(a) Estimates of recent average service delivery unit costs:
   a. Training at sub-district level: Approximately US$150 per 10 people/day. Average cost decreases for more trainees or longer trainings.
   b. Training at province level: Approximately US$ 450 per 10 people/day. Average cost decreases for more trainees or longer trainings.
   c. Public service message: radio - US$775.00; TV – US$1550;
   d. Training module development: US$9,300
   e. Cash allowances (approximately US$ 17.50/month/child are based on existing cash allowances.

Overall, costs are based upon experience from implementation of prior Global Fund grants as well as implementation of MOPH activities.

(b) Estimates expected to remain about the same with increase of 5%/year for inflation adjustment.
(c) The M&E component of the proposal contains a detailed method for measuring unit costs to determine cost effectiveness. SRs will also be responsible for unit cost measurement while administering programs.

5.4.4 Measuring service unit cost and cost effectiveness Provide the following: (d) where available, estimates of recent average service delivery unit costs at the program-level for key services with an explanation of how the estimates were developed; (e) estimates of the expected average service delivery unit costs for key services that are included in the proposal; and (f) a description of how key service delivery unit costs will be measured at the program-level, over time throughout the lifecycle of the grant.
HALF PAGE MAXIMUM

5.5 Funding Requests in the Context of a Common Funding Mechanism

→ In this section, common funding mechanism refers to situations where all funding is contributed into a common fund for distribution to implementing partners

5.5.1 Common funding mechanism If the country's response to HIV is through a program-based approach, does the proposal plan for some or all of the requested funding to be paid into a common-funding mechanism to support that approach?	☐ Yes *→ complete all of section 5.5*
	☐ ⦿ No *→ do not complete section 5.5*

5.5.2 Operational status of common funding mechanism Describe the main features of the common funding mechanism, including the fund's name, objectives, governance structure and key partners.
HALF PAGE MAXIMUM
5.5.3 Measuring performance Describe how program performance helps determine financial contributions to the common fund.
HALF PAGE MAXIMUM
5.5.4 Additionality of Global Fund request Describe how the funding requested in the proposal will contribute to the achievement of outputs and outcomes that would not be supported by current or planned resources available to the common funding mechanism.
HALF PAGE MAXIMUM

5B. CROSS CUTTING HSS – FUNDING REQUEST

Read the Round 10 Guidelines to consider including optional cross-cutting HSS interventions

SECTION 5B can only be included in the Round 10 HIV proposal if:

- the applicant submitted section 4B with HIV.

Section 5B can be downloaded from the Global Fund's website if the applicant intends to apply for cross-cutting HSS interventions.

CHECKLIST

Section 3 and 4: Proposal Summary and Program Description		Document attached? → *mark an 'X' if attached*	List document name and number
4.1	National Health Sector Development / Strategic Plan	X	• Summary of the 10th National Health Development Plan (2007-2011) (Annex1)
4.1	National HIV Control Strategy and/ or Costed Implementation Plan	X	• National Plan for Strategic and Integrated HIV and AIDS Prevention and Alleviation, 2007-2011 (Annex2)
4.1	Sub-sector policies that are relevant to the proposal (e.g. national or sub-national human resources policy, norms and standards, gender policies/strategies and plans, policies on community or CSO partnerships with government health or other systems)	X	• National Women's Development Plan in the Tenth National Economic and Social Development Plan (2007-2011) (Annex 3)
4.1	Most recent self-evaluation reports/technical advisory reviews, including any epidemiology report directly relevant to the proposal	X	• Report on Gap analysis on Young Children Affected by HIV/AIDS in Thailand, January 2009 (Annex4) • 2010 UNGASS Country Progress Report (Annex5)
4.1	National Monitoring and Evaluation Plan (e.g. health sector, disease-specific, or other)	X	• Consensus Recommendations: National Evaluation Agenda for HIV/AIDS in Thailand (Annex6)
4.1	National policies to achieve gender equality in regard to the provision of HIV prevention, treatment, and care and support services to all people in need.	X	It is stated in the National Plan for Strategic and Integrated HIV and AIDS Prevention and Alleviation, 2007-2011 (Annex1)
4.1	Most recent bio-behavioral surveillance of key population(s)		No data available

4.1	National report on gender specific operational research and any gender analysis/assessments that might have been undertaken of the HIV response		No data available
4.1	National pharmacovigilance policy		Not applicable
4.2 (b)	Map if proposal targets specific region/population group	X	• Map of program sites and tables of implementing provinces by year and SDA (Annex7)
4.3.2	Any recent report on health system weaknesses and gaps that impact outcomes for the three diseases (and beyond if it exists)	X	• The THAILAND Rapid situation analysis of HRH implication of scaling up for UA to HIV/AIDS prevention treatment and care (Annex8)
4.4	Document(s) that explain basis for coverage targets	X	Targets for implementation of HIV Round 10 proposal (Annex9)
4.4.1	**A completed Performance Framework (mandatory)**	**X**	**Performance Framework**
4.4.1	**A detailed work plan (mandatory)**	**X**	**work plan**
4.4.2	A copy of the Technical Review Panel (TRP) Review Form from Round 8 or 9, if relevant	X	• Technical Review Panel Review Form from Round 9 (Annex10)
4.6.1	A recent evaluation of the Impact Measurement Systems as relevant to the proposal (if one exists)	X	• Thailand Multiple Indicator Cluster Survey, Dec 2005-Feb 2006 (Annex11)
4.7.1	A recent assessment of the Principal Recipient capacities (other than Global Fund Grant Performance Report)		Both PRs do not have other assessments.
4.7.1	Documents describing the organization, such as official registration papers, summary of recent history of		Not applicable

	organization, management team information *→ only for Non-CCM applicants*		
4.7.2	List of Sub-recipients already identified (including name, sector they represent, and SDA(s) most relevant to their activities during the proposal term)	X	List of Sub-recipients of HIV Round 10 proposal (Annex12)
4.8.6	A completed HIV Pharmaceutical and Health Products List *→ only mandatory if applicant is procuring these products*		Not applicable
Section 4B: Cross-cutting HSS (only one per country's application)		Document attached? *→ mark an 'X' if attached*	List document name and number
4B.2	A completed separate cross-cutting HSS Performance Framework (mandatory, if applicable)		Not applicable
4B.2	A detailed separate cross-cutting HSS work plan (mandatory, if applicable)		Not applicable
Section 5: Funding Request		Document attached? *→ mark an 'X' if attached*	List document name and number
5.2	A detailed budget (mandatory)	X	detailed budget
5.4.2	Information on basis for budget calculation and diagram and/or list of planned human resources funded by proposal	X	Basis for budget calculation of planned human resources funded by proposal (Annex13)
5.4.3	Information on basis of costing for 'other' cost category items		• Not applicable for 'other' cost category • Basis for budget calculation of training cost category funded by proposal (Annex14)

5.5.1	Documentation describing the functioning of the common funding mechanism *→ only include if there is a common funding mechanism*		Not applicable
5.5.2	Most recent assessment of the performance of the common funding mechanism *→ only include if there is a common funding mechanism*		Not applicable

Section 5B: Cross-cutting HSS Funding Request		Document attached? → *mark an 'X' if attached*	List document name and number
5B.1	A separate cross-cutting HSS detailed budget (mandatory, if applicable)		detailed budget
5B.4.2	Information on basis for budget calculation and diagram and/or list of planned human resources funded by proposal (only if relevant)		
5B.4.3	Information on basis of costing for 'other' cost category items		
Other documents relevant to sections 3, 4 and 5 attached by applicant		Document attached? → *mark an 'X' if attached*	List document name and number

PROPOSAL FORM – ROUND 10
SINGLE AND MULTI-COUNTRY APPLICANT

Performance Framework: Indicators, Targets and Periods Covered

HIV

Program Details

Country:	Thailand
Disease:	HIV/AIDS
Proposal ID:	TH R10 proposal

Program Goals, impact and outcome indicators

Goals:	
1	Children affected by HIV and AIDS (CABA), and other vulnerable children living within communities of high HIV prevalence enjoy the same standards of social acceptance, personal development and quality of life as others.
2	

Impact indicator number	Impact indicator formulation	Baseline			Targets							Comments*	Responsible organization
		value	Year	Source	Year 1	Report due date	Year 2	Report due date	Year 3	Year 4	Year 5		
1	% of children with advanced HIV infection receiving ART (aged 15 and below)	68.7%	2009	National AIDS database (NHSO)	71.00%		73.00%		77.00%	81.00%	85.00%	In 2009 Thailand reported 8, 076 children aged 15 and below receiving ART (2010 UNGASS). Thailand is in process of apply a new treatment guideline using 350 CD4 for those who are eligible for ART. Therefore it is estimated 11,759 children aged 15 and lower with advance HIV infection (with 350 CD4) in 2009 to be as demoninator for calculating baseline for 2009. During 2008 to 2009, Thailand reported no improvement of ART coverage for children receiving ART. With a strong support from the GF round 10, It is estimated to improve ART coverage to 85% at the end of the program (2015). It is noted we estimate 2% increase for the first 2 year (phase I) and 4% increase when program is well developed and getting to phase II of its implementation.	Pact and NAMC
2	% of Children affected by HIV and vulnerable children aged 5-18 who reported improvement in their well-being	NA	2006	MICS (Multiple Indicator Cluster Survey)	TBD				TBD		TBD	National AIDS Committee plans to pursue this indicator as a core national indicator for next strategic plan (2012-2016) since Thailand will emphasize on holistic approach and quality of services in addition to coverage. The program will be pilot tested the measurement method at the first year of the project and then target will be set.	Pact and NAMC

Outcome indicator number	Outcome indicator formulation	Baseline			Targets							Comments*	Responsible organization
		value	Year	Source	Year 1	Report due date	Year 2	Report due date	Year 3	Year 4	Year 5		
1	% of orphaned and vulnerable children aged 0-17 whose households received free basic external support in caring for OVC (at least one)	21.4%	2006	MICS (Multiple Indicator Cluster Survey)	22.50%				TBD		60.00%	The site selection based on covering around 60% of children affected by HIV and AIDS in each region of the country. Thailand plan to undertake in-depth analysis of the coming MISC in 2010, that pursue coverage of those CABA who received at least 3 care and support to monitor progress on coverage of essential package of service.	Pact and NAMC
2	% of women aged 15-49 expressing accepting attitudes towards family members infected with HIV	63.30%	2006	MICS (Multiple Indicator Cluster Survey)	68.00%				TBD		82.00%	it is estimated only 5% increased in 2010 because it has no intensive intervention in the community. At the end of the program with strong S/D intervention, it is expected to improve 30% at the end 2006 or early of 2007 from baseline in 2006 (64% to 82%). Thailand plan to undertake composite index analysis of the coming MISC in 2010 from all 4 questions asking in the MISC including (see MISC tool, UNICEF).	Pact and NAMC
3	% of children who was born from HIV infected mothers received follow up on HIV status	55.90%	2007	special surway by DOH	59.00%				64.00%		73.00%	it is estimated only 5% increased in 2010 because it has no intensive intervention before the project. During the program period with strong linkage of clinical with care and social support services and mother has better understanding, it is estimated to improve follow rate for HIV status to 64% at the mid of project (2013) and 73% at the end of project (2015). Data source is HIVQUAL (Quality improvement in HIV care and treatment) for pediatric that implement all hospitals in Thailand.	Pact and NAMC

* please specify source of measurement for indicator in case different to baseline source.

Program Objectives, Service Delivery Areas and Indicators

Objective Number	Objectives:
1	Strengthened and coordinated policies and systems integrating child-sensitive, HIV-related health care, community involvement, and social protection for quality service delivery
2	Equal and universal access to high quality, gender-responsive essential health and social services for CABA as well as for other vulnerable and marginalized children
3	Increased social acceptance and inclusion for those infected and affected by HIV, as well as for those marginalized due to other causes
4	Strengthened national, provincial, district and sub-district (including community) strategic information systems for improvement of services to vulnerable children
5	
6	

Indicator Number	Objective Number	Service Delivery Area	Indicator formulation	Baseline (if applicable)			Targets for years 1 and 2				Annual targets for years 3, 4, and 5			Tied to	Targets cumulative Y-over program term Y-cumulative annually N-not cumulative	Baselines included in targets (Y/N)	Top 10 indicator	DTF: Name of PR responsible for implementation of the corresponding activity	Comments
				Value	Year	Source	6 months	12 months	18 months	24 months	Year 3	Year 4	Year 5						
1/1	1	Health Systen Strengthening	Number of hospitals establishing case management approach	6	2007	DOH (Pilot Project)	21	42	63	84	126	168	210	Current grant	Y - over program term	N	Not Top 10	DDC	1)This indicator will count number of hospitals wheres case management for children is established according to the standard guideline.; 2) 80% of target hospitals are able to establish the case management system.
1/2	1	Health Systen Strengthening	Number of orphanages implementing new guidelines	0	2010	MSDHS	0	0	29	59	151	151	151	Current grant	Y - over program term	N	Not Top 10	DDC	1) The first year will be the process of reviewing and testing new guidelins, thus the implementation of the new guideline, which need capacity building of staff can start in year 2 onward.; 2) All governmental and private orhanages will implement this new guideline by yr 4.
1/3	1	Health Systen Strengthening	Number of health care providers trained on specific skilled needed to provide age and gender specific services to children	1,073	2010	DOH	900	4,850	6,410	9,350	12,530	15,170	17,810	Current grant	Y - over program term	N	Top 10	DDC	Four training curriculum includes 1. Implementation of Case Management System 2. Training on psychosocial support 3. Teacher training curricula revision 4. Strengthen male involvement within context of PMTCT
1/4	1	Health Systen Strengthening	Number of care providers in orphanages and day care centers trained	447	2010	MSDHS	0	250	500	750	1,000	1,250	0	Current grant	Y - over program term	N	Top 10	DDC	1) The first 6 months of the program will be for preparation of curriculum.
1/5	1	Community System Strengthening	Number of individuals in sub-district child action group (CAG) trained on mapping and needs assessment of CABA and vulnerable children in a community	0	2010	MSDHS	0	5,580	7,440	11,160	18,600	33,480	33,480	Current grant	Y - over program term	N	Top 10	DDC	1) The first 6 month of the program will be for preparation of SRs and SSRs. 2)This indicator will count only number of CAG members trained in formal way. After formal training, they will be provided technical assistance by SSRs. 3) All target CAGs will be trained by year 3; 4) In yr 4, 80% of CAGs can mobilize local resource for training.
1/6	1	Community System Strengthening	Number of sub-district child action groups (CAG) functioning	0	2010	MSDHS	0	279	409	669	1,332	1,488	1,581	Current grant	Y - over program term	N	Not Top 10	DDC	1) The first 6 month of the program will be for preparation of SRs and SSRs. 2).This indicator will count CAG who has work plan for CABA and vulnerable children in their subdistricts or received local fund for child support activites 3) 85% of CAGS in target provinces are expected to be functioning over program term
1/7	1	Social Protection System Strengthening	Number of staff trained on developed national standard or policy on alternative care and child protection	0	2010	MSDHS	390	780	1,170	1,560	2,340	3,120	3,900	Current grant	Y - over program term	N	Top 10	DDC	1) The national standard and policy for alternative care will be developed in Q1. 2) The MSDHS will collect data on training.
1/8	1	Social Protection System Strengthening	Number of provincial child protection committee functioning	NA	2010	MSDHS	10	19	29	29	29	29	29	Current grant	Y - over program term	N	Not Top 10	DDC	1) Definition of functioning of provincial child protection committee will be described and communicated to the provinces in Q1. 2) The MSDHS will be responsible for assessing the functioning of the committee.
2/9	2	Health System: Service delivery	Number of children received age-approriate health service	NA	2010	DOH	0	0	0	4,350	15,660	26,970	26,970	Current grant	Y - over program term	N	Top 10	DDC	The first year will be for developing approriate modules for training of staff and training, which need high skill to provide services according to developed modules.
2/10	2	Community System: Service delivery	Number of care takers and families received skills building training or technical assistance to provide care for CABA and vulnerable children	NA	2010	MSDHS		5,580	16,740	27,900	66,960	111,600	159,030	Current grant	Y - over program term	N	Top 10	DDC	1) The first 6 month of the program will be for preparation of SRs and SSRs. 2) This indicator will count care takers and families through family camps or group activities or home visits in each year. 3) Care takers or family of every CABA are targeted to be trained at least once a year. 4) Training in yr 5 will be totally supported from local resource mobilization.
2/11	2	Social Support Service Delivery	Number of children received economic support	2,012	2009	MSDHS	558	1,367	1,143	2,035	3,290	3,290	3,290	Current grant	Y - over program term	N	Top 10	DDC	The economic support includes 1) Seed money for Income generation activities for families 2) Cash transfers to ethnic minority family
2/12	2	Social Support Service Delivery	Number of children with kinship or foster care/ families received social support	4,000	2009	MSDHS	0	870	3,190	3,770	4,930	6,960	8,120	Current grant	Y - over program term	N	Top 10	DDC	The first six month will be the revision and develop modules for training and training.
3/13	3	Promoting contribution of PHA network to reduce stigma in all settings	Number of IEC materials/issues developed through capacity building for PLHIV,YPLHIV for stigma reduction communication	15	2010	ACCESS		40	132	219	396	573	663	Current grant	Y - over program term	Y	Not Top 10	ACCESS	1) This indicator will count number of prototypes of IEC materials developed by PLHIV and YLHIV; 2) Small grants will be provided to each province for PLHIV and YLHIV for develop IEC material; 3) PLHIV and YLHIV groups in each province will produce message for community radio; 4) Prototypes of IEC materials will be produced for use in target provinces.
4/14	4	Health system strengthening information system	Number of people receiving training and technical assistance in M&E	9,253	2010	HIV R8	119	351	544	745	381	340	283	Current grant	Y - over program term	N	Not Top 10	DDC	The M&E modules will be developed specifically to this proposal and level of trainees.
4/15	4	Health system strengthening information system	Number of individuals in sub-district child action group trained on using strategic information for program improvement and advocacy	0	2010	MSDHS	12	132	182	300	168	132	168	Current grant	Y - over program term	N	Not Top 10	DDC	The M&E modules will be developed specifically to this proposal and level of trainees.